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# POLICY REPORT

Workers'  
Compensation  
BoardCommission  
des accidents  
du travailFebruary 1993  
Vol. 6 No. 1

## Employer classification & 1993 assessment rates

On December 9, 1992, amendments to Regulation 1102 (formerly Regulation 951) were signed by the Lieutenant Governor. The amendments, effective January 1, 1993, restructure the industries listed in Schedule 1 of the *Workers' Compensation Act* (the *Act*), and provide classification rules to govern the way business activities are assigned to the new rate groups. The WCB will phase in the assessment rates for the new classification structure over a 3-year transition period.

On October 27, 1992, the WCB's Board of Directors, following consultation with both the employer and worker communities, made a number of decisions relating to the new employer classification structure and 1993 assessment rates. In brief, these are the decisions (highlighted text). Each decision is followed by background information about the classification scheme. (The next edition of *Policy Report* will introduce the new classification scheme in detail.)

### Employers classified in 219 rate groups in 1993

The WCB's classification structure divides employer operations in Ontario into 9 industry classes:

- A Forest Products
- B Mining and Related Industries
- C Other Primary Industries (e.g., farming)
- D Manufacturing
- E Transportation and Storage
- F Retail and Wholesale Trades
- G Construction
- H Government and Related Services (e.g., education, health care)
- I Other Services (e.g., janitorial, hospitality)

For the purposes of accurate classification and assessment, employers in each class are further divided into rate groups, based on the employer's business activities. Where previously there were 109 rate groups, there are now 219 groups.

### NOTICES SENT

In December, 1992, the WCB sent letters to all employers with information about their 1993 assessment rate(s). This information included the specific rate group(s) and rate group number(s) under which their business activities now fall.

### Payroll reporting and assessments continue at rate group levels in 1993

Below the rate group level, employer operations are further subdivided into one or more of 835 classification units (CUs). A CU may contain one business activity only, or it may contain many similar business activities. For example, in Class A, Forest Products, there is a CU for Sawmill and Planing Mill Products. Employers whose operations are classified in this CU are all engaged in one, some, or all of the business activities included in sawmill and planing mill operations such as the drying of lumber, the sawing and planing of lumber from round wood, the production of cooperage stock, fuelwood, mine timbers, or wood lath.

**In 1993, all employers are to report their payroll information and accidents by their rate group numbers.** All WCB forms and correspondence relating to employer assessments indicate the rate group numbers.

Eventually, once the CU system is in full operation, the WCB will file allemployer payroll and claims data at the CU level. Employers will be informed well in advance of the start-up date. In the meantime, when the WCB registers new employers, it classifies their operations at the CU level for internal purposes only. Employers currently on the system have also been assigned CUs.

### Assessment rate increases/decreases no more than 3%

Introduced with the new classification scheme is a new pricing system which was used to calculate the target assessment rates for the new rate groups. Originally, the target rates were to be reached in roughly equal steps over a 3-year transition period, with the WCB calculating individual *transition assessment rates* for each employer in each year. But, after extensive deliberation, the Board of Directors agreed that due to the weak economy the 1993 transition assessment rates had to be modified.

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Thus, for single-rated employers\*, if the 1993 target rate for their rate group is greater than their 1992 actual assessment rate, their individual 1993 transition assessment rate is either a) or b), whichever is less.

- a) The 1992 actual assessment rate, plus 1/3 the difference between the 1993 target rate and the 1992 actual assessment rate

OR

- b) The employer's 1992 actual assessment rate, plus 3%.

To illustrate when an employer would qualify under a), consider an employer whose 1992 actual assessment was \$2.00 and whose 1993 target assessment rate is \$2.09. The calculations are:

$$\begin{aligned} \text{a) } \$2.00 + 1/3 (\$2.09 - \$2.00) &= \\ \$2.00 + 1/3 (\$0.09) &= \\ \$2.00 + \$0.03 &= \$2.03 \end{aligned}$$

OR

$$\begin{aligned} \text{b) } \$2.00 + 3\% &= \\ \$2.00 + \$0.06 &= \$2.06 \end{aligned}$$

In this example, calculation a) is the lesser rate. So, this employer's 1993 assessment rate is \$2.03.

In the following example, the employer's 1993 transition assessment rate is determined by calculation b). The employer's 1992 actual assessment rate was \$2.10 and the 1993 target rate is \$2.40. The calculations are:

$$\text{a) } \$2.10 + 1/3 (\$2.40 - \$2.10) = \$2.20$$

OR

$$\text{b) } \$2.10 + 3\% = \$2.16$$

Using the 1/3 calculation in a) results in a 1993 increase greater than 3%. Since the modification requested by the Board of Directors limits increases to no more than 3% of an employer's 1992 actual assessment rate, this employer's 1993 transition assessment rate is \$2.16 [calculation b)].

If, on the other hand, an employer's target assessment rate for 1993 is lower than the employer's 1992 actual assessment rate, that employer's 1993 rate is either a) or b), whichever is greater.

- a) The 1992 actual assessment rate, minus 1/3 of the difference between the 1993 target rate and the 1992 actual assessment rate

OR

- b) The employer's 1992 actual assessment rate, minus 3%.

**The ceiling  
on each  
worker's assessable  
earnings  
is \$52,500.**

Assessment rates are expressed as a dollar amount for each \$100 of the total assessable earnings for all workers on an employer's payroll. For each covered worker, assessable earnings include all wages and any other remuneration that can be given a dollar value, e.g., salary, vacation pay, commissions, etc., up to an annual earnings ceiling set out in s.38(1)(c) of the Act. That earnings ceiling, in 1993, works out to \$52,500.

The new classification structure, and the new pricing system, will continue to be monitored by WCB administrators and the Board of Directors in light of emerging economic developments. □

Discussion papers related to the issues covered in this article may be obtained from Policy Publications.

- \* For details about multi-rated employers and more information on the 1993 assessment rates, read the WCB's 1993 *Guide for Completing the Employer's Statement of Payroll*. The Guide was mailed to all employers registered in Ontario.

For further revenue information, contact

Employer Registration and  
Assessment Branch  
Revenue Department  
Workers' Compensation Board

(416) 923-3925

1-800-926-8638

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# Policy publications

## – 1992 review

With this issue of *Policy Report* we start our 6th year of publishing and distributing policy information to the WCB's internal and external stakeholders.

### Policy Report

Described by WCB staff as its "most highly rated publication," *Policy Report* was published 6 times in 1992 and distributed to some 10,400 internal and external readers.\* In response to requests from WCB employees, distribution was increased in late 1992 to include all staff. We print 12,000 copies of each issue to allow for those who want extras. To request copies of back issues, contact Usha Kapoor at (416) 927-4941. If we've run out we'll be glad to send you photocopies.

Three of the 6 issues published in 1992 were substantially larger than normal. July's issue included a 4-page article on earnings ceilings which detailed how these ceilings changed from 1975 to 1992. September's issue focused on the WCB's community approach to medical rehabilitation. December's "Claims Adjudication – An Overview" looked at the adjudication process and included a 3-page flow chart.

Once again, an index of articles published over the past 5 years is enclosed in this issue of *Policy Report*.

### Operational Policy manual

Seven packages of new or updated *Operational Policy* (OP) manual documents were distributed to subscribers in 1992.

In response to user requests, new or revised policies are being edited for plain language prior to being submitted to executive management for approval.

Additionally, Policy Publications writers will begin reviewing older documents and updating them to present information in plain language. All new or updated manual documents reference the revised *Act* – RSO 1990.

WCB staff are now able to view the OP manual and the *Act*, and cross reference between the two on a computer system known as the Operational Policy System. Policy Publications staff now update the online OP manual within 2 working days of new or revised policies being minuted.

In 1992, we conducted the first of what will be an annual audit of the OP manual. All subscribers were sent a list of current documents with instructions to delete out-of-date documents, and to return the audit to Policy Publications indicating missing documents. This audit will take place again in mid-1993, and subscribers are encouraged to complete the audit to ensure that their manuals are up-to-date.

### Employer Classification manual

In 1992, Policy Publications began working with the Revenue Policy Branch and RESET project staff on the Employer Classification (EC) manual. Now in its second draft, the EC manual is available in hard copy for WCB staff, and can also be viewed online. The new EC manual is an invaluable tool for Revenue Department staff who are responsible for ensuring that all employers are classified according to their business activities in the appropriate rate group.

The final draft of the EC manual will be available to the public mid-year, at a price yet to be determined. Details will follow in subsequent issues of *Policy Report*.

\* WCB Non-Bargaining Employee Opinion Survey, 1991 ☐

## New OHIP policy ... no effect on WCB

Starting January 1, 1993, OHIP no longer pays for medical assessments/ reports requested by third parties. For example, OHIP no longer pays for reports required by an insurance company for an individual's life insurance application.

The question arose: Does this new OHIP policy affect medical assessments/ reports related to workers' compensation claims?

The answer is no!

The Ministry of Health and the WCB have an agreement regarding the payment of medical services for *work-related* injuries/diseases. Under this agreement:

- Physicians submit their accounts regarding the assessment/ treatment of work-related injuries/ diseases to OHIP.
- OHIP pays the physicians for these accounts.
- The WCB, in turn, reimburses the Ministry of Health for the costs of assessment/treatment of work-related injuries.

Because the WCB continues to pay for medical services required for work-related injuries or diseases, OHIP's new policy has *no* effect on the payment of reports or assessments physicians submit to the WCB in relation to a claim. ☐



## Revised Act Now Available

The *Workers' Compensation Act, RSO 1990*, (sections 1 to 151 only) is available for \$10.70 (includes GST) from

Publications Ontario  
880 Bay Street  
Toronto, Ontario  
M7A 1N8  
Tel. (416) 326-5300

OR

Access Ontario  
Rideau Centre  
50 Rideau Street  
Ottawa, Ontario  
K1N 9J7  
Tel. (613) 238-3630  
FAX (613) 787-4055

Payment may be made by sending cheque, money order, or your VISA or Mastercard number (and expiry date) to either of the above addresses.

Publications Ontario expects the complete *Act*, including the Regulations and Schedules 1 and 2, to be available for purchase in early 1993. ☐

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Subscriptions to *Policy Report* are free on request to this address.

## WCB Bilingual Lexicon —2nd Edition

Have you got your 2nd edition of the WCB's Bilingual Lexicon? The lexicon is the official compilation of WCB terminology. This expanded version includes over 2,200 terms with explanatory notes and medical abbreviations, allowing Board personnel and external stakeholders to communicate more effectively in both official languages.

For easy reference, the lexicon is divided into 2 sections: English-French and French-English; the terms in both sections are in alphabetical order. The document is housed in custom, slant-D ring, vinyl binders, separated by dividers with mylar coated tab dividers.

For a copy of the Lexicon (\$15.50 + 7% GST) or an update for your existing Lexicon (\$5.30 + 7% GST), please send your prepayment by cheque or money order payable to:

WCB – ACCOUNT: 4711-62901

Address: Policy Publications  
Benefits Policy Branch  
Workers' Compensation Board  
22nd floor, 2 Bloor St. East  
Toronto, Ontario  
M4W 3C3  
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Allow 3 to 4 weeks for delivery. ☐





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# La Loi révisée est maintenant disponible

La Loi sur les accidents du travail, L.R.O. 1990 (articles 1 à 151) est disponible au prix de 10,70 \$, TPS comprise. S'adresser à :

Publications Ontario  
880, rue Bay  
Toronto (Ontario)  
M7A 1N8  
TEL : (416) 326-5300

Accès Ontario  
Centre Rideau  
50, rue Rideau  
Ottawa (Ontario)  
K1N 9J7  
Téléphone : (613) 238-3630  
Télécopieur : (613) 787-4055

Le paiement peut se faire par chèque, mandat, ou au moyen de la carte de crédit VISA ou MasterCard (indiquer le numéro et la date d'expiration).

Publications Ontario prévoit que la Loi intégrale, y compris les Règlements et les annexes 1 et 2, sera disponible au début de 1993. ☐

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Afin de nous assurer que vous recevez chaque numéro du *Bulletin des politiques* et de garder nos frais de poste à la baisse, nous devons tenir notre liste d'envoi à jour. Veuillez donc communiquer tout changement d'adresse au :

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**Commission des accidents du travail**  
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**M4W 3C3**  
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Labonnement au *Bulletin des politiques* est gratuit sur demande à l'adresse susmentionnée.

## Publication des politiques

### Manuel de classification des employeurs

En 1992, la Section de la publication des politiques a commencé à travailler avec la Direction des politiques sur le revenu et le

personnel du projet REPARS en vue de produire le Manuel de

classification des employeurs. Ce

manuel, actuellement à l'étape de la

seconde ébauche, est disponible,

pour le personnel de la CAT, en

version imprimée; le manuel est

également accessible par ordinateur.

Il s'agit d'un outil précieux pour le

personnel de la Direction du revenu

chargé de faire en sorte que tous les

employeurs soient classifiés selon

leurs activités commerciales dans les

groupes de taux appropriés.

L'ébauche définitive du Manuel de

classification des employeurs sera

offerte au grand public vers le milieu

de l'année, à un prix non encore fixé.

Nous donnerons plus de détails dans

un prochain numéro.

\* *Sondage d'opinion auprès des employés non syndiqués de la CAT, 1991* ☐

## Lexique bilingue de la CAT - 2<sup>e</sup> édition

Possédez-vous votre exemplaire de la 2<sup>e</sup> édition du Lexique bilingue de la CAT? Le lexique renferme la terminologie officielle en usage à la CAT. La nouvelle édition renferme plus de 2 200 entrées accompagnées de notes explicatives et d'abréviations médicales; cet ouvrage permet aux membres du personnel de la Commission et aux groupes d'intérêt externes de communiquer de manière efficace dans les deux langues officielles.

Le lexique est divisé en deux sections, anglais-français et français-anglais, et les termes sont disposés par ordre alphabétique. L'ouvrage est offert dans une reliure en vinyle, à trois anneaux, avec intercalaires munis d'onglets revêtus de mylar.

Pour obtenir un exemplaire du Lexique, faites parvenir la somme de 15,50 \$ plus TPS de 7 % (mise à jour : 5,30 \$ plus TPS de 7 %), par chèque ou mandat, à :

CAT - COMPTE : 4711-62901

Adresse : Publication des politiques

Direction des politiques sur

l'indemnisation

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Téléphone : (416) 927-4941

Veuillez prévoir un délai de livraison de trois à quatre semaines. ☐





# Publication des politiques

— Survol de 1992

Le présent numéro du *Bulletin des politiques* marque la 6<sup>e</sup> année de préparation et de diffusion de renseignements sur les politiques aux personnes et groupes intéressés, internes et externes de la CAT.

## Bulletin des politiques

Le *Bulletin des politiques*, qualifié par le personnel de la CAT comme étant sa « publication la plus hautement considérée », a été publié six fois en 1992 et il a été distribué à quelque 10 400 lecteurs\*, tant à l'interne qu'à l'externe. En réponse à la demande exprimée par les employés de la CAT, la distribution a été accrue à la fin de 1992 pour s'étendre à tout le personnel. Chaque numéro est tiré à 12 000 exemplaires, ce qui permet de remettre des exemplaires supplémentaires à ceux qui en font la demande. Pour obtenir des exemplaires supplémentaires d'un numéro, veuillez communiquer avec Usha Kapoor au (416) 927-4941. Si un numéro est épuisé, nous vous enverrons des photocopies.

Trois des six numéros parus en 1992 ont été plus volumineux qu'à la normale. Le numéro de juillet comprenait un article de quatre pages sur le plafond des gains : on y expliquait comment le plafond avait été modifié entre 1975 et 1992. Le numéro de septembre était axé sur l'approche communautaire de la CAT. En PO, Nous avons fait parvenir à tous les abonnés une liste des documents actuels et leur avons demandé de retirer les documents périmés, et de retourner la liste à la Section de la publication des politiques, en indiquant les documents manquants. Une telle vérification se produira chaque année et la prochaine aura lieu vers le milieu de 1993. Les abonnés sont invités à prendre part à la vérification pour s'assurer que leur manuel est bien à jour.

Le présent numéro du *Bulletin des politiques* comprend un index des articles parus au cours des cinq dernières années.

## Manuel des politiques opérationnelles

Sept envois de documents nouveaux ou révisés, tirés du Manuel des politiques opérationnelles (PO), ont été effectués en 1992.

En réponse à la demande des usagers, les politiques, nouvelles ou révisées, font l'objet d'un travail de simplification avant d'être soumises à l'approbation de la haute direction.

Par ailleurs, les rédacteurs entreprendront sous peu la révision des documents antérieurs et en feront la mise à jour en fonction du langage simplifié. Tous les documents du manuel, nouveaux ou révisés, renvoient à la Loi révisée (L.R.O. 1990).

Grâce au système des politiques opérationnelles, le personnel est maintenant en mesure de consulter le texte du manuel des PO et de la Loi directement sur écran de visualisation et même d'établir des renvois entre les deux textes. Le personnel chargé de la publication des politiques peut maintenant effectuer la mise à jour du manuel des PO dans les deux jours ouvrables qui suivent l'adoption des politiques nouvelles ou révisées.

En 1992, nous avons effectué la toute première vérification du manuel des PO. Nous avons fait parvenir à tous les abonnés une liste des documents actuels et leur avons demandé de retirer les documents périmés, et de retourner la liste à la Section de la publication des politiques, en indiquant les documents manquants. Une telle vérification se produira chaque année et la prochaine aura lieu vers le milieu de 1993. Les abonnés sont invités à prendre part à la vérification pour s'assurer que leur manuel est bien à jour.

(suite à la page 4)

## L'OHIP et la CAT

Depuis le 1<sup>er</sup> janvier 1993, l'Assurance-santé de l'Ontario (OHIP) ne paie plus les évaluations médicales ou les rapports médicaux demandés par des tiers. Par exemple, l'OHIP ne paie plus les rapports exigés par un assureur pour la proposition d'assurance-vie d'un particulier.

La question se pose : Cette nouvelle politique de l'OHIP influence-t-elle sur les évaluations médicales ou les rapports médicaux relatés à des demandes d'indemnisation? La réponse : non.

Le ministère de la Santé et la CAT ont conclu une entente sur le paiement des services médicaux qui se rattachent à des lésions ou des maladies *relées au travail*. En vertu de cette entente :

- Les médecins présentent leurs comptes se rapportant à l'évaluation ou au traitement des lésions ou maladies *relées au travail* à l'OHIP.
- L'OHIP paie les médecins.
- La CAT rembourse le ministère de la Santé des coûts de l'évaluation ou du traitement des lésions ou maladies *relées au travail*.

Comme la CAT continue de payer les services médicaux requis en raison de lésions ou de maladies *relées au travail*, la nouvelle politique de l'OHIP n'influe pas sur le paiement des évaluations ou des rapports médicaux que les médecins soumettent à la CAT au sujet d'une demande d'indemnisation. □



Le Bulletin des politiques est maintenant imprimé sur du papier recyclé, exempt d'acide, et ce, sans frais supplémentaires.



## Les augmentations ou diminutions des taux de cotisation sont limitées à 3 %

L'introduction du nouveau mode de classification s'accompagne d'une nouvelle méthode de fixation des taux; cette méthode a été utilisée pour calculer les taux de cotisation des nouveaux groupes de taux. Initialement, les taux cibles devaient être atteints selon des stades à peu près identiques au cours d'une période de transition de trois ans; pendant cette période, la CAT devait calculer chaque année les taux de cotisation *transitoires* de chaque employeur. Après un examen minutieux, le conseil d'administration a convenu qu'il fallait modifier les taux de cotisation *transitoires* de 1993 en raison de la faiblesse de l'économie.

Ainsi, pour les employeurs à taux unique\*, si le taux de cotisation cible de 1993 du groupe de taux est supérieur au taux de cotisation réel de 1992, le taux de cotisation *transitoire* de 1993 sera le *moindre* de a) ou de b) :

- a) le taux de cotisation réel de 1992 majoré du tiers de la différence entre ce taux et le taux de cotisation cible de 1993,
- b) le taux de cotisation réel de 1992 majoré de 3 %.

Pour illustrer l'application du taux de cotisation selon le volet a), prenons le cas d'un employeur dont le taux de cotisation réel de 1992 est de 2,00 \$ et dont le taux de cotisation cible de 1993 est de 2,09 \$. Le calcul est le suivant :

$$\begin{aligned} \text{a) } 2,00 \$ + 1/3 (2,09 \$ - 2,00 \$) \\ 2,00 \$ + 1/3 (0,09 \$) \\ 2,00 \$ + 0,03 \$ = 2,03 \$ \end{aligned}$$

OU

$$\text{b) } 2,00 \$ + 3 \% \\ 2,00 \$ + 0,06 \$ = 2,06 \$$$

Dans cet exemple, le volet a) donne le taux le moins élevé. Le taux de cotisation de 1993 de cet employeur est ainsi de 2,03 \$.

Dans l'exemple qui suit, le taux de cotisation *transitoire* de 1993 de l'employeur est déterminé par l'application du volet b). Le taux de cotisation de 1992 de l'employeur était de 2,10 \$ et le taux cible de 1993 est de 2,40 \$. Le calcul est le suivant :

$$\begin{aligned} \text{a) } 2,10 \$ + 1/3 (2,40 \$ - 2,10 \$) = 2,20 \$ \\ \text{OU} \\ \text{b) } 2,20 \$ + 3 \% = 2,26 \$ \end{aligned}$$

- a) le taux de cotisation réel de 1992 diminué du tiers de la différence entre ce taux et le taux de cotisation cible de 1993,
- b) le taux de cotisation réel de 1992 diminué de 3 %.

## Le plafond des gains assurables de chaque travailleur est de 52 500 \$

Les taux de cotisation sont exprimés en un montant par 100 \$ de gains assurables totaux pour tous les travailleurs figurant sur la liste de paye. Pour chaque travailleur couvert, les gains assurables comprennent tout salaire et toute rémunération pouvant être exprimée en dollars, exemple : salaire, indemnité de congé, commissions, etc, sous réserve du plafond des gains annuels fixé dans l'alinéa 38 (1) c) de la Loi. Pour 1993, ce plafond s'établit à 52 500 \$.

La nouvelle structure de classification, ainsi que la nouvelle méthode de fixation des cotisations, continueront d'être surveillées par les administrateurs de la CAT et le conseil d'administration à la lumière de la conjoncture économique. □

Des documents de travail portant sur les points dont il est question au présent article sont disponibles auprès de la Section de la publication des politiques.

\* Pour obtenir des précisions au sujet des taux de cotisation de 1993 et des employeurs à taux multiples, veuillez consulter le *Guide de 1993 pour remplir l'Etat de la masse salariale de l'employeur*. Le *Guide* a été envoyé à tous les employeurs inscrits en Ontario.

Si vous avez des questions au sujet du revenu, veuillez communiquer avec la :

Direction de l'inscription des employeurs et des cotisations  
Service du revenu  
Commission des accidents du travail

(416) 923-3925  
1-800-926-8638

## BULLETIN DES POLITIQUES

### Veuillez adresser vos questions ou commentaires à la :

Rédactrice  
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Commission des accidents du travail  
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## Classification des employeurs et taux de cotisation de 1993

Le 9 décembre 1992, les modifications apportées au Règlement 1102 (anciennement le Règlement 951) recevaient l'approbation du lieutenant-gouverneur. Entrées en vigueur le 1<sup>er</sup> janvier 1993, ces modifications restreignent les industries énumérées à l'annexe 1 de la Loi sur les accidents du travail (la Loi) et elles fournissent des règles servant à déterminer de quelle manière les activités commerciales sont attribuées aux nouveaux groupes de taux. La CAT introduira graduellement les taux de cotisation selon la nouvelle structure de classification sur une période de trois ans.

Le 27 octobre 1992, le conseil d'administration de la CAT, à la suite de consultations auprès des employeurs et des travailleurs, prenait un certain nombre de décisions au sujet de la nouvelle structure de classification et des taux de cotisation de 1993. Ces décisions sont indiquées en jaune. Chaque renseignements de base sur le mode de classification. (Dans le prochain numéro du *Bulletin des politiques*, nous traiterons du nouveau mode de classification en détail.)

### Les employeurs sont classifiés en 219 groupes de taux en 1993

La structure de classification de la CAT répartit les secteurs d'exploitation des employeurs de l'Ontario dans neuf catégories :  
A Produits forestiers  
B Industries des mines et industries connexes  
C Autres industries des matières premières (p. ex., fermes)  
D Industries manufacturières  
E Transport et entreposage  
F Commerce de détail et commerce de gros

G Construction  
H Services gouvernementaux et services connexes (p. ex., éducation, soins médicaux)  
I Autres services (p. ex., conciergerie, services de réception)

Pour parvenir à une classification et une cotisation qui soient précises, les employeurs de chaque catégorie ont été classifiés en groupes de taux, selon leurs activités commerciales. Il y avait autrefois 109 groupes de taux, il y en a maintenant 219.

### ENVOI DES AVIS

En décembre 1992, la CAT a fait parvenir une lettre à tous les employeurs pour les aviser des taux de cotisation de 1993. Cette lettre précisait les groupes de taux applicables à chaque employeur, ainsi que les numéros de groupes de taux correspondant à leurs activités commerciales.

### La déclaration de la masse salariale et les cotisations continueront de se faire au niveau des groupes de taux en 1993

Au-delà du groupe de taux, les secteurs d'exploitation des employeurs sont de nouveau classifiés en 835 unités de classification (UC). Une UC peut ne renfermer qu'une seule activité commerciale, comme elle peut en renfermer plusieurs qui sont semblables. Par exemple, dans la catégorie A, «Produits forestiers», il y a une UC pour l'industrie des produits de scieries et d'ateliers de rabotage. Les employeurs dont les secteurs d'exploitation sont classifiés dans cette UC exercent tous une ou

plusieurs des activités reliées à l'exploitation de scieries ou d'ateliers de rabotage telles que le séchage du bois de construction, le sciage et le rabotage du bois de construction tiré du bois rond, la production du bois à fusaux, du bois de chauffage, du bois de mine ou de lattes de bois.

En 1993, tous les employeurs doivent déclarer les renseignements sur leur masse salariale et les accidents en utilisant les numéros de groupes de taux. Tout formulaire et toute correspondance de la CAT ayant trait aux cotisations des employeurs portent l'indication du numéro de groupe de taux.

Lorsque le système des UC sera complètement en place, la CAT inscrira toutes les données se rapportant à la masse salariale des employeurs et aux demandes d'indemnisation au niveau des UC. Les employeurs seront avisés d'avance de la date de prise d'effet de ces mesures. Entre temps, lorsque la CAT fait l'inscription des nouveaux employeurs, elle classifie leurs secteurs d'exploitation au niveau des UC à des fins internes seulement. Les employeurs déjà inscrits se sont vu attribuer des UC.

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# POLICY REPORT



Workers'  
Compensation  
Board

Commission  
des accidents  
du travail

March 1993  
Vol. 6 No. 2

## Employer Classification – An Overview

The Workers' Compensation Act (Act) applies to all employers whose operations in Ontario are represented by the industries listed in Schedules 1 and 2 of the Act. These employers finance the workers' compensation system and, in doing so, are provided in most cases with no-fault insurance, protecting them from costly and time-consuming lawsuits.

The WCB's classification scheme divides employer operations in Ontario into industry *classes*. These classes are then subdivided into *rate groups* and, below that, into *classification units* (CUs).

The CUs cover

- all industries listed under Schedule 1 (Employers in these industries must be registered with the WCB.)
- employer operations that can be transferred from Schedule 2 to Schedule 1, by application
- employer operations not covered by the *Act* that can be added to Schedule 1, by application.

Each CU includes one or more business activities. Business activities and operations include all of those listed in the 1980 edition of Statistics Canada's *Standard Industrial Classification (SIC)* manual.

See insert for more information on how employees are classified.

### Classifying employers

When employers register, the WCB records the business activity, assigns a CU, and classifies them in the appropriate rate group. The WCB's decision is based on employers' descriptions of their business activities. To ensure accurate classification, the WCB may consider other sources of information, such as

- business contracts
- direct competitors
- equipment used
- on-site inspections
- staff duties.

Employers may provide brochures, pamphlets, photos, and product samples to assist in the classification process. All employers' classifications are subject to review by WCB auditors. (See *Classification reviews*, page 2.)

If Schedule 1 employers fail to fully register with the WCB, fail to provide sufficient information regarding their business activities, or engage in a business activity that is not listed in a CU, the WCB classifies them in the CU it considers most appropriate.

When registered employers change, add, or delete business activities, they must immediately report to the WCB to ensure that they are correctly classified, assessed, and charged for claims costs.

The WCB determines how a change, addition, or deletion of activities affects the employer's classification. For example, the WCB may find that certain of the employer's business activities require a separate CU, or even that the entire operation should be moved to another CU.

### Changes to classification

Employers must inform the WCB of a change in business activity by letter, in person, or when they report payroll and remit assessments to the WCB.

The WCB is legislated to administer the Act and is responsible for classifying and assessing Schedule 1 employers according to their business activities. Each business activity is assigned to a classification unit (CU) within a rate group. An employer's rate group is the basis for determining the employer's assessment.



*The Act guarantees that employers' workers, if they sustain work-related injuries or diseases, are compensated for loss of income and the costs of rehabilitation and health care. Thus insured, injured workers lose the right in most cases to take independent legal action against their own employers or co-workers.*

## Classification reviews

Employers requesting a review of their classification may do so by writing or visiting the WCB. A review might be requested because there was not enough information available to classify the employer accurately at the time of registration and, as a result, the WCB determined a provisional classification for the employer.

More wide-ranging classification reviews of an entire CU or rate group may be requested by a number of employers or by an employer association in one CU or rate group. The request may be prompted by technological changes, economic trends, new methods of doing business, or because a CU or rate group is part of an industry that is in decline.

The WCB also monitors CUs and rate groups and makes changes as it sees fit. The WCB might initiate a review because of changing trends in historical cost experience. In other cases, an industry might be in decline and, over time, certain rate groups may no longer meet existing credibility thresholds. The WCB may then merge these rate groups with others in the same class, or it may revisit the criteria for determining credibility. Careful consideration is given to the short- and long-term effects that the loss or addition of a substantial number of employers may have on a particular rate group.

The WCB's Classification Review Committee meets regularly to deal with classification issues and undertakes a general classification review of all CUs and rate groups every 2 to 3 years.

## Classification rules

Classification rules and conditions for single and multiple classification apply to all employers in Schedule 1 on a compulsory basis or by application.

Although most employers carry on a single business activity and are classified in a single CU and rate group, some employers with more complex operations may be eligible, or required, to be classified in multiple CUs and rate groups. Guidelines used by the WCB to determine if an employer's operations qualify for multiple classification follow.

**Payroll and wage records** – Once the WCB has established that an employer is carrying on distinct business activities, the most important criterion for multiple classification is the status of the employer's payroll and wage records.

The WCB encourages all employers engaged in multiple business activities to maintain **segregated** payrolls and wage records for each business activity. A payroll is considered segregated if the wages applicable to each business activity are separated in a way that can be verified by records maintained for purposes other than reporting to the WCB. If the payrolls for separate business activities are kept segregated, the employer satisfies the necessary condition for multiple classifications.

If an employer records the assessable earnings of all workers on one payroll with no regard to the business activity in which each worker is engaged, the payroll is considered **aggregated**. If there is only one payroll, the employer is not eligible for multiple classification, and the employer's entire payroll is classified and assessed in the rate group with the highest assessment rate.

**Small employers** – The WCB makes an exception to the aggregated payroll rule for small employers. For this purpose, the WCB defines a small employer as one whose total annual assessable earnings are less than 5 times the ceiling placed on a worker's annual assessable earnings. (See



## Ancillary operations

- design, including drafting and engineering, research, and development related to goods produced or services provided, or intended to be produced or provided, by the employer
- operation of a plant to produce power or heat for the employer's use
- operation of maintenance or repair shops for the purpose of servicing or repairing the employer's vehicles or equipment
- inventory control
- the manufacture of packaging or packing materials to be used in the packaging of goods produced by the employer
- printing or lithography directly onto, or for use on, goods produced or sold by the employer
- warehousing or distribution of goods produced or sold by the employer
- transportation of an employer's personnel or of goods produced or sold by the employer
- wholesaling of goods produced by the employer
- security of an employer's own premises
- administration related to the employer's operations
- repairs carried out by an employer on goods produced or sold by the employer
- marketing, promotion, or communication related to goods produced or services provided, or intended to be produced or provided, by the employer
- training of personnel relating to the employer's business activities
- any operations carried out entirely or partly for the employer's personnel, including cafeterias, commissaries, parking lots, or medical, recreational, or day care facilities.

*Assessment rates*, page 4.) When this is the case, a small employer's payroll is classified and assessed according to the rate group that makes up the largest percentage of the employer's annual assessable earnings.

**Ancillary operations** (see list at left) — The WCB defines an ancillary operation as one that supports, or is incidental to, the employer's business activity.

Thus, ancillary operations have the same classification as the employer's business activity. If an operation is ancillary to 2 or more business activities, its payroll is applied proportionally according to the assessable earnings under each business activity.

**Associated employers** — For the purpose of assessment, the WCB may aggregate or combine the payrolls of associated employers. This only happens when the WCB determines that the operations of the associated employers are such that, if the operations were carried out by one employer only, the operation of the other would be considered ancillary.

Generally speaking, employers are associated if the following conditions apply:

- the employers are related to each other
- an employer is a corporation and another employer has a controlling interest in the corporation either directly or through a relation
- the employers are corporations and are controlled by the same individual or related individuals or groups
- the employers are partnerships with common partners entitled to 50% or more of the profits of each partnership.

**Contracting out** — When employers contract out all or part of a business activity to another employer, the WCB classifies any remaining business activity as if nothing had been contracted out.

The remaining activity stays in the same rate group as the activity contracted out.

**Example:** A firm which operates in the printing industry, and has been classified in the rate group for printing, decides to contract out the actual printing process. The firm's remaining activities relate only to clerical support, usually considered an ancillary operation. However, in the case of contracting out, the WCB continues to classify the clerical support staff in the rate group for the printing industry.

**Bankruptcy and receivership** — When an employer's business is in receivership or bankruptcy, or when a receiver is preparing to sell or close a business, the WCB considers the employer's business activities to be the same as they were originally. Therefore, they remain classified in the same rate group—unless they are *special operations*.

**Start-up operations** — All operations required by an employer to start up a business activity are classified and assessed at the rate of assessment applicable to the business activity—unless they are *special operations*.

**Special operations** — A special operation (see list, page 4) forms part of, or operates in conjunction with, a business activity. When carried on as a separate business, a special operation is a business activity in its own right. But, as part of another business activity, it acquires a special status.

If the employer keeps segregated wage records for the special operation, that operation is classified and assessed separately. However, if the employer has not segregated the wage records of a special operation from the wage records of the business activity, the employer's entire payroll is assessed at the higher of the business activity rate or the special operation

rate.



*Schedule 1 employers, who are collectively liable for their injured workers' benefits, pay assessment premiums to the accident fund of the WCB.*

*Schedule 2 employers, on the other hand, are each liable for the total costs of benefits for their injured workers. These employers individually deposit funds with the WCB to cover the costs of claims for their workers.*

*Schedule 2 employers, and any other employers whose industries are not listed or described in either Schedule 1 or Schedule 2, can apply to the WCB for the same coverage as that at of Schedule 1 employers.*

## **POLICY REPORT**

Policy Report is published under the authority and direction of the Benefits Policy Branch of the Workers' Compensation Board. If there is any conflict between the statements contained in this publication and the Workers' Compensation Act and/or Board approved policy documents, the Act or the approved document governs.

**Comments or inquiries should be addressed to:**

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Graphics Services, Communications

**Example:** A general contractor who is classified in the general contracting rate group also demolishes buildings as part of the contract work. Demolition is a higher-risk operation than general contracting and has a higher assessment rate. If the employer keeps separate payrolls, the employer's operations are classified in separate rate groups, one for general contracting and one for demolition.

However, if the employer keeps only one aggregated payroll for both activities, the entire payroll is assessed at the higher rate for demolition.

**Special operations —** The following is a list of all special operations:

- high-rise forming
- structural steel erection and steel reinforcing
- demolition
- construction of large bridges
- construction, logging, and millwright and rigging work performed by employers not in these respective industries
- motor vehicle service and repairs, restaurants, or home improvements and renovations carried on as a business as part of a larger retail operation.

## **Assessment rates**

For the purpose of calculating an employer's assessment, the WCB annually sets a rate for each rate group based on the rate group's collective claims experience. (The lower the group's collective historical costs, the lower the rate.) Rates are expressed as a dollar amount for each \$100 of the employer's annual assessable earnings relating to the employer's workers. For each covered worker, assessable earnings include any remuneration that can be given a dollar value, e.g., salary, vacation pay, commissions, room and board, etc., up to the annual earnings ceiling, which in 1993 is \$52,500.

**Per-claim limit —** Employers within a rate group are collectively responsible for the costs of their claims, up to a per-claim limit. The per-claim limit is 2½ times the annual assessable earnings ceiling for workers in the year of the accident. In 1993, the calculated per-claim limit is \$131,250. Employers within a class are collectively responsible for the costs of claims over the per-claim limit recorded.

## **Unfunded liability**

A portion of every Schedule 1 employer's assessment pays for the ongoing costs of accident claims registered in previous years. These ongoing costs are referred to as the *unfunded liability*. Like the costs above the per-claim limit, the costs of the unfunded liability — for all rate groups in each class — are pooled at the class level. The costs are then charged back to each rate group on a pro rata basis that ensures both equity and stability.

## **Application date**

The policies referred to in this article are effective as of January 1, 1993.

## **Revenue Information**

For further information, please contact:

Employer Registration and Assessment Branch  
Revenue Department  
Workers' Compensation Board  
(416) 927-3925  
1-800-387-8638







## Secteurs d'exploitation auxiliaires

- La conception, y compris le dessin industriel et l'ingénierie, la recherche et le développement rattachés aux biens produits ou aux services offerts, ou aux biens et services devant être produits ou offerts, par l'employeur; l'exploitation de centrales énergétiques et de centrales thermiques destinées à l'usage de l'employeur;
- l'exploitation d'ateliers d'entretien ou de réparation, ou la réparation, ou les deux, des véhicules ou des machines de l'employeur;
- le contrôle des stocks;
- la fabrication de matériel d'emballage ou d'emballage destiné à l'emballage des biens produits par l'employeur;
- les travaux d'imprimerie ou de lithographie sur les biens produits ou vendus par l'employeur, ou destinés à ces biens;
- l'entreposage ou la distribution de biens fabriqués ou vendus par l'employeur;
- le transport des biens fabriqués ou vendus par l'employeur ou le transport du personnel;
- la vente en gros de biens fabriqués par l'employeur;
- la sécurité des lieux de travail de l'employeur;
- les tâches administratives rattachées aux activités de l'employeur;
- les réparations sous garantie effectuées par un employeur sur les biens fabriqués ou vendus par l'employeur;
- les activités de commercialisation, de promotion ou de communication reliées aux biens produits ou aux services offerts, ou aux biens et services devant être produits ou offerts, par l'employeur;
- la formation du personnel dans le cadre des activités commerciales de l'employeur;
- toute activité exercée en tout ou en partie pour le personnel de l'employeur, y compris l'exploitation de magasins de compagnie, de cafétérias, de terrains de stationnement, d'installations médicales, récréatives ou de garde d'enfants.

**Secteurs d'exploitation auxiliaires** — La CAT définit les secteurs d'exploitation auxiliaires comme ceux qui servent à appuyer les activités principales de l'employeur, ou qui y sont complémentaires. (Voir la liste de gauche.) Ainsi, de tels secteurs d'exploitation sont assujettis à la même classification que les activités principales de l'employeur. Si un secteur d'exploitation est auxiliaire par rapport à plus d'une activité principale, la masse salariale s'y rapportant est répartie proportionnellement, selon les gains assurables se rapportant à chaque activité commerciale.

**Employeurs associés** — Aux fins de cotisation, la CAT peut regrouper la masse salariale des employeurs associés. Cela ne se produit que lorsque la CAT détermine que les secteurs d'exploitation des employeurs associés sont tels que, si les secteurs étaient gérés par un seul employeur, les secteurs d'un employeur seraient considérés comme auxiliaires par rapport aux autres.

En règle générale, les employeurs sont associés lorsque les conditions suivantes s'appliquent :

- les employeurs ont un lien de parenté,
- un employeur forme une société constituée et un autre employeur détient un bloc de contrôle, soit directement soit par l'entremise d'une personne avec laquelle il a un lien de parenté,
- les employeurs forment des sociétés constituées contrôlées par la même personne ou des personnes ou groupes ayant un lien de parenté,
- les employeurs forment des sociétés en nom collectif dont les associés ont droit à 50 % au moins des bénéfices de chaque société.

**Sous-traitance** — Lorsqu'un employeur offre une partie ou l'ensemble d'une activité commerciale en sous-traitance à un autre employeur, la CAT classe le reste de l'activité commerciale comme si rien n'avait été offert à contrat. Le reste de l'activité demeure dans le même groupe de taux que la partie offerte à contrat.

**Exemple** : Une entreprise engagée dans l'industrie de l'imprimerie, classifiée dans le groupe de taux de l'imprimerie, offre en sous-traitance ses travaux d'imprimerie. Elle se réserve les services de soutien administratif, comme habituellement considérés comme secteur d'exploitation auxiliaire. Comme une partie de l'activité a été offerte en sous-traitance, la CAT continue de classifier le personnel de soutien administratif selon le groupe de taux de l'industrie de l'imprimerie.

**Faillite et mise sous séquestre** — Lorsqu'un employeur est en faillite ou mis sous séquestre, ou lorsqu'un syndicat s'apprête à vendre ou à liquider une entreprise, la CAT considère les activités commerciales de l'employeur comme étant les mêmes qu'apparaissant. Ainsi, les activités continuent d'être classifiées dans le même groupe de taux, à moins qu'il ne s'agisse de secteurs d'exploitation requis pour le démarrage d'une activité commerciale d'un employeur sont classifiées et donnent lieu à une cotisation fixée au taux applicable à l'activité commerciale, à moins qu'il ne s'agisse de secteurs d'exploitation particuliers.

**Secteurs d'exploitation particuliers** — Un secteur d'exploitation particulier (voir la liste à la page 4) fait partie d'une activité commerciale ou est géré conjointement avec celle-ci. Lorsqu'il est géré séparément, le secteur d'exploitation particulier devient une activité commerciale en lui-même. Il a, toutefois, un statut particulier lorsqu'il s'inscrit dans le cadre d'une autre activité commerciale.

Si l'employeur tient des registres de salaires distincts pour ses secteurs d'exploitation particuliers, ces secteurs sont classifiés séparément et donnent lieu à une cotisation distincte. Cependant, si l'employeur n'a pas séparé les registres de salaires des secteurs d'exploitations particuliers de ceux des activités commerciales, l'ensemble de la masse salariale de l'employeur se voit attribuer une cotisation fixée en fonction du taux le plus élevé de l'activité commerciale ou du secteur d'exploitation particulier.



L'inscription, n'étaient pas suffisants pour classifier correctement l'employeur. La CAT avait en conséquence établi une classification provisoire pour l'employeur. Il peut arriver que certains employeurs ou qu'un regroupement d'employeurs faisant partie d'une UC ou d'un groupe de taux demandent la révision plus approfondie de toute une UC ou de tout un groupe de taux. La demande peut être motivée par des changements technologiques, des tendances économiques, de nouvelles méthodes d'affaires, ou encore parce qu'une UC ou un groupe de taux fait partie d'une industrie qui est en déclin.

La CAT examine les UC et les groupes de taux et elle apporte les modifications qu'elle estime nécessaires. Elle pourrait entreprendre une révision en raison de nouvelles tendances dans les résultats en matière de coûts d'accidents. Par ailleurs, une industrie pourrait être en déclin et au fil des ans, il pourrait arriver que certains groupes de taux ne respectent plus les seuils de crédibilité établis. La CAT pourrait alors fonder de tels groupes de taux avec d'autres de la même catégorie, ou elle pourrait réexaminer les critères de crédibilité. Une attention particulière est accordée aux effets à court et à long terme que peut avoir sur un groupe de taux particulier l'ajout ou la soustraction d'un nombre important d'employeurs.

Le Comité de révision de la classification de la CAT se réunit régulièrement pour traiter des questions rattachées à la classification; ce comité effectue une révision générale de toutes les UC et de tous les groupes de taux tous les deux ou trois ans.

## Règles sur la classification

Les règles et les conditions se rapportant à la classification unique ou multiple s'appliquent à tous les employeurs de l'annexe 1, que leur inscription ait été obligatoire ou facultative.

Même si la plupart des employeurs n'exercent qu'une seule activité commerciale et ne sont classifiés que dans une UC et un seul groupe de taux, il se peut que certains employeurs ayant des activités plus complexes aient le droit d'être classifiés dans des UC et des groupes de taux multiples, ou qu'ils doivent l'être. Nous énonçons ci-après les directives utilisées par la CAT pour déterminer si la classification multiple s'applique aux secteurs d'exploitation d'un employeur.

### Liste de paye et registres de salaires

Une fois que la CAT a établi qu'un employeur exerce plusieurs activités commerciales distinctes, le critère le plus important qui se rapporte à la classification multiple est l'état de la liste de paye et des registres de salaires de l'employeur.

La CAT incite tous les employeurs qui exercent plusieurs activités commerciales à tenir des listes de paye et des registres de salaires **distincts** pour chaque activité commerciale. Une liste de paye est considérée comme distincte si les salaires applicables à chaque activité commerciale sont séparés d'une manière pouvant être vérifiée au moyen de registres tenus pour des fins autres que pour la déclaration à la CAT. Si les listes de paye se rapportant aux activités commerciales diverses sont tenues séparément, l'employeur satisfait à la condition requise pour la classification multiple.

Si un employeur inscrit les gains assurables de tous les travailleurs dans une seule liste de paye, sans égard à l'activité commerciale dans laquelle est employé le travailleur, la liste de paye est dite **regroupée**. S'il n'y a qu'une liste de paye, l'employeur n'est pas admissible à la classification multiple, l'ensemble de sa masse salariale est classifiée selon le groupe de taux ayant le taux de cotisation le plus élevé, et la cotisation est fixée en conséquence.

### Employeurs de petite taille

La CAT fait une exception à la règle sur la liste de paye regroupée dans le cas des employeurs de petite taille. La CAT définit, à cet égard, l'employeur de petite taille comme celui dont le montant annuel des gains assurables représente moins de cinq fois le plafond annuel des gains assurables d'un travailleur. (Voir *Taux de cotisation*, à la page 4). Dans le cas des employeurs de petite taille, la CAT classifie la masse salariale selon le groupe de taux qui représente le plus fort pourcentage des gains assurables annuels de l'employeur et fixe la cotisation en conséquence.

En vertu de la Loi, si  
un travailleur subit une  
lésion ou contracte une  
maladie reliées au  
travail, il est indemnisé  
pour la perte de revenu,  
pour les coûts de  
réadaptation et pour les  
soins médicaux. Le  
travailleur blessé,  
pendant qu'il est ainsi  
assuré, abandonne son  
droit d'intenter des  
poursuites contre  
l'employeur ou ses  
collègues de travail.





## Survol de la classification des employeurs

En vertu du mode de classification de la CAT, les secteurs d'exploitation des employeurs de l'Ontario sont répartis dans des catégories d'industries. Ces catégories sont subdivisées en groupes de taux puis en unités de classification (UC).

Les UC englobent :

- toutes les industries qui figurent à l'annexe 1 (les employeurs de ces industries doivent s'inscrire auprès de la CAT);

- les secteurs d'exploitation des employeurs qui peuvent, sur demande, passer de l'annexe 2 à l'annexe 1;

- les secteurs d'exploitation des employeurs qui ne sont pas couverts par la Loi mais qui peuvent être ajoutés à l'annexe 1, sur demande.

Chaque UC représente une ou plusieurs activités commerciales. Les activités commerciales et les secteurs d'exploitation comprennent toutes les activités et tous les secteurs qui sont énumérés dans la *Classification type des industries (CTI)*, édition de 1980, de Statistique Canada.

Voilà l'encart pour avoir plus de précisions sur la classification des employeurs.

### Méthode de classification

Lorsqu'un employeur s'inscrit auprès de la CAT, celle-ci enregistre l'activité commerciale, attribue une UC et classe l'employeur dans le groupe de taux approprié. La décision de la CAT repose sur les descriptions que fournissent les employeurs de leurs activités commerciales. Afin d'établir une classification exacte, la CAT peut utiliser diverses sources de renseignements, telles que :

- les contrats d'affaires,
- le nom de tout concurrent direct,
- l'équipement utilisé,
- les inspections sur place,
- les tâches du personnel.

Les employeurs peuvent fournir des brochures, des dépliant, des photos et des échantillons de produits pour aider à la classification. Toute classification est sujette à la révision de la part des vérificateurs de la CAT. (Voir *Révision de la classification*, ci-dessous).

Si un employeur de l'annexe 1 néglige de s'inscrire auprès de la CAT ou de fournir des renseignements suffisants au sujet de ses activités commerciales, ou encore s'il exerce une activité commerciale qui n'est pas comprise dans une UC, la CAT classe cet employeur dans l'UC qu'elle estime la plus appropriée. Lorsqu'un employeur inscrit modifie ses activités commerciales, ou qu'il en ajoute de nouvelles ou en soustrait certaines, il doit en aviser la CAT sans tarder afin de faire en sorte qu'il est correctement classifié et qu'il se voit attribuer les cotisations et les coûts d'indemnisation exacts.

La CAT détermine comment une modification, un ajout ou une soustraction d'activité influe sur la classification d'un employeur. La CAT peut constater, par exemple, que certaines des activités commerciales d'un employeur exigent une UC distincte, ou même que l'ensemble du secteur d'exploitation devrait être affecté à une autre UC.

### Modification de la classification

Les employeurs doivent aviser la CAT de tout changement survenant dans leurs activités commerciales, et ce, par lettre, en personne, ou lors de la déclaration de la masse salariale et du paiement des cotisations à la CAT.

### Révision de la classification

Les employeurs qui désirent obtenir la révision de leur classification doivent écrire à la CAT ou se rendre à ses bureaux. Une révision pourrait être demandée, par exemple, parce que les renseignements, fournis au moment de

La Loi sur les accidents du travail (la Loi) s'applique à tous les employeurs dont les secteurs d'exploitation en Ontario sont représentés par les industries énumérées aux annexes 1 et 2 de la Loi. Ces employeurs financent le régime d'indemnisation des travailleurs; en contrepartie, ils bénéficient d'une assurance sans égard à la responsabilité qui les protège contre des poursuites judiciaires dispendieuses et qui prennent beaucoup de temps.

La CAT a comme mission législative d'appliquer la Loi; elle est responsable de la classification des employeurs de l'annexe 1 et de l'imposition des cotisations à ces employeurs en fonction de leurs activités commerciales. Chaque activité commerciale est affectée à une UC à l'intérieur d'un groupe de taux. Le groupe de taux de l'employeur est l'élément de base dans la détermination de la cotisation.



# POLICY REPORT



Workers'  
Compensation  
Board

Commission  
des accidents  
du travail

June 1993  
Vol. 6 No. 3

## Bulletin

*Here are the important features of new and revised policies applied since January 1, 1993. Refer to your Operational Policy (OP) manual for the full text of policies and guidelines.*

### Job-search assistance in local & regional labour markets

The Board provides, as part of a Vocational Rehabilitation (VR) plan, job-search assistance for up to 6 months for workers who are able to actively look for work. This assistance can be extended for a further 6 months if

- the degree of the worker's impairment requires an extensive job search
- the worker agrees to a change in the vocational objectives
- there is an unanticipated change in the labour market.

Now, following a review of these guidelines, if after 6 months the worker has not found a job and further assistance is being provided, the focus of the job search switches from the local to the regional labour market.

#### (07-03-09, Job Search Assistance)

In December, 1992, the Board of Directors approved the addition of new guidelines to broaden the worker's area of job search from the local labour market to regional markets.

When caseworkers develop VR plans for workers prior to first determining their future economic loss (FEL) benefit, the plans must be based on job opportunities in the local labour market, unless the worker voluntarily agrees to look for employment in the regional or provincial market.

If, prior to the first FEL review (in the 24th month after a FEL determination), VR services are continuing and the worker has not found a job, the caseworker, the worker, and the employer must amend and sign the VR plan to expand the job search to the regional labour market. The caseworker amends the plan before referring the file to the FEL adjudicator for first review.

### Exceptions

Plans are not amended to search the regional labour market if

- at the time of first review, the worker has had little time to complete an exhaustive job search in the local labour market
- relocation would impose significant personal hardship on the worker
- relocation would have a significant negative impact on the career prospects of the worker's spouse
- the worker is of an age that, along with the Board, they agree that relocation is not a viable option.

#### (07-02-08, Identifying a VR Objective)

Section 52 allows the Board to pay a worker's relocation expenses if moving to a new place in Ontario helps the worker return to permanent employment. Relocation expenses may include some of the costs of moving e.g., transportation, discharge of a lease, sale of residence.

### Expansion of job-search activity at & after 1st FEL review

### Relocation of injured workers under s. 52



## **Relocation of injured workers under s. 52 (cont'd)**

Here are some of the criteria that must be met before a worker's relocation expenses are paid:

- the worker must have a job offer in the new area
- no other injured worker already living in the new area is available for the new job opportunity
- no suitable job opportunity exists in the worker's normal location
- the worker is not eligible for the Canada Employment & Immigration Commission's Mobility Programme (CEICMP), or CEICMP assistance does not cover the worker's relocation costs
- the distance and time to get from the worker's home to the new job is
  - greater than that involved in commuting to the pre-accident job, and
  - at least 100 kms or 2 hours travel each way.

### ***(07-03-12, Relocation of Injured Workers Under s.52)***

## **Training participants – policy proposal**

On April 30, 1993, the WCB completed the second round of consultation on coverage for individuals on unpaid work placements authorized by a training agency. The Board of Directors approved the policy proposal in principle and directed that it come into effect July 1, 1993. This policy replaces the interim guidelines which expire on June 30, 1993.

As with the interim guidelines, in the new policy

- the training participant is a "learner" under the definition of "worker" and is entitled to workers' compensation benefits if injured while working for the placement employer
- the employer with whom the trainee is placed to gain work experience is the "employer" and is protected from civil liability if the trainee is injured.

As of February 18, 1993, the Ontario government pays the compensation costs if trainees are in Ontario government-sponsored programs. Discussions are underway between the Board and Employment and Immigration Canada (EIC) on funding coverage for EIC placements.

### ***(01-02-13, Training Participants – Interim guidelines)***

## **FEL & changes to net exemption code**

If a worker's net exemption code (NEC) changes **after** the initial FEL determination, a recalculation using the new NEC takes place at the **next** FEL review. However, if an incorrect NEC was used to determine a FEL benefit, the Board will do the calculation again using the correct NEC.

At the time of the FEL review, the recalculated FEL benefit including the changed NEC is always compared to the previous amount, and

- if the difference between the new and the old calculations is less than 10%, the benefit is not changed
- if the difference between the new and the old calculation is 10% or more, the worker gets the new amount.

***(See Transmittal number 25 for 05-05-15, FEL: Changes to Net Exemption Code.)***



### **Payment for missed or cancelled medical appointments**

As of January 1, 1993, the Board does not pay for medical appointments--examinations, treatments, NEL assessments--missed or cancelled by workers.

**(See Transmittal number 25 for 06-02-02, Medical.)**

### **Compensation advances by employer – pension and FEL supplements**

The Board deducts from a worker's benefits, any payments that the employer has advanced the worker for lost time resulting from a work-related accident.

As a result of a recent policy review, deductions for employer advances are also made from pension and FEL supplements that started or continued after July 1, 1993. However, employer advances are not deducted from workers'

- pension benefits (pre-1989 *Act(s)*)
- NEL benefits, and
- FEL benefits.

**(See Transmittal number 25 for 05-01-04, Compensation Advances by Employer.)**

### **Automatic deduction of family support payments**

The *Family Support Plan Amendment Act*, 1991, requires that automatic family support deductions are made from periodic income sources when Support Deduction Orders (SDOs) are issued.

The Board automatically deducts support payments from a worker's compensation benefits when it receives an SDO or a notice of an SDO from the Family Support Plan.

Benefits subject to deduction include

- arrears payments of periodic benefits
- temporary total benefits
- temporary partial benefits
- permanent partial impairment pensions (pre-1990)
- s.147 permanent partial impairment supplements
- pre-bill 162 permanent partial impairment supplements
- FEL benefits and FEL supplements
- NEL benefits paid in periodic payments.

The total amount deducted is usually not greater than 50% of what the Board is paying the worker in periodic benefits. But, if the worker also receives periodic income from a source other than the Board, the amount deducted by the Board may be greater than 50%.

**(05-01-15, Automatic Deduction of Family Support Payments)**

### **Assessment of vacation pay for short-term employees**

As of January 1, 1988, when an employer is calculating WCB assessments, all money paid to a short-term employee as vacation pay is considered earnings, which must be added to the worker's regular wages for the actual pay-period worked.

Example: A short-term worker earns \$200 in regular wages and \$50 in lump-sum vacation pay for 2 weeks work. The employer calculates WCB assessments on the worker's total earnings of \$250 for the 2-week period.



## Assessment of vacation pay for short-term employees (cont'd)

This change replaces the "conversion method" which was used to calculate 1988 and 1989 assessments. Under the conversion method, vacation pay was converted into equivalent days paid and added on to the period worked.

Employers who used the conversion method for these 2 years may be entitled to a rebate. Call the Employer Audit Branch at 927-3820 for details.

### **(08-04-14, Vacation and Severance Pay for Short-term Employees)**

## Hearing-loss policies updated

The Board updated its three hearing-loss policies because of changes brought about by Bill 162. The essential features for determining entitlement to benefits have not changed and are consistent with Board Minute #4 of June 3, 1988, Page 5238.

### **Noise-induced hearing loss and tinnitus**

The updated noise-induced hearing loss (NIHL) and tinnitus policies deal with claims that have an accident date on or after January 2, 1990.

Besides entitlement guidelines, the NIHL document (04-03-10) includes

- a description of the rating schedule used for determining permanent impairment (the *AMA Guides*)
- a method of determining the decibel level of noise exposure that is equivalent to continuous noise exposure for 8 hours per day over 5 years
- a method of determining benefits when there is age-related hearing loss, a pre-existing condition, or out-of-province exposure
- a comparison chart of operating procedures for claims with accident dates before and after January 2, 1990.

The revised tinnitus policy (04-03-11) shows how to assess permanent impairments using the *AMA Guides*.

NIHL and tinnitus develop and progress over many years. A claim may be submitted to the Board many years after the first signs of an impairment. Therefore, the existing NIHL and Tinnitus policies (04-03-06 and 04-03-07 respectively), are kept in the *OP* manual since the previous rating schedule will occasionally be required for pre-January 2, 1990 claims.

### **Traumatic hearing loss**

The updated traumatic hearing loss (THL) policy (03-03-02) deals with claims that have accident dates on or after January 2, 1990. The only change from the previous policy is the use of *AMA Guides* for determining permanent impairments. The policy also clarifies the existing methods of determining the level of benefits if there is a pre-existing condition or an age-related hearing loss.

## REMINDER !

**To all parties in the design and development of a VR Plan – the VR caseworker, the injured worker, the employer and, if possible, the treating doctor!**

Signing the plan is intended to show your input in its design, and a commitment to doing your part to make it work. A VR plan can always be modified or a new one developed to meet changing circumstances. But, in every case, the VR plan must be signed.



# 1993 facts and figures

	1992	1993
<b>Indexing factor</b>	4.4%	1.6%

<b>Earnings ceilings for injuries/diseases occurring</b>	1992	1993
before Apr. 1, '85 (pre-1985 <i>Act</i> )	\$ 37,700	\$ 38,400
Apr. 1, '85 to Jan. 1, '90 inclusive (pre-1989 <i>Act</i> )	42,200	42,900
Jan. 2, '90 to Dec. 31, '90 inclusive (1990 <i>Act</i> )	42,200	42,900
Jan. 1, '91 to Dec. 31, '91 inclusive	43,900	44,700
Jan. 1, '92 to Dec. 31, '92 inclusive*	50,800	51,700
Jan. 1, '93 to Dec. 31, '93 inclusive		52,500
*From Jan. 1, 1992 and on, the earnings ceiling is based on the average industrial wage X 175%.		

<b>Annual indexed dollar amounts</b>	1992	1993
survivors' lump sum	\$ 53,075.99	\$ 53,925.21
survivors' adjustment factor	1,326.90	1,348.13
NEL base amount	49,235.00	50,022.76
NEL adjustment factor	1,094.00	1,111.50

<b>Late filing charge</b>	1992	1993
	\$ 250	\$ 250

<b>Post-judgement interest rate</b>	<b>Quarter</b>			
	1st	2nd	3rd	4th
1990	14%	15%	15%	14%
1991	14%	11%	11%	10%
1992	9%	9%	8%	7%
1993	10%	8%	7%	



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**Policy Report** is published under the authority and direction of the Benefits Policy Branch of the Workers' Compensation Board. If there is any conflict between the statements contained in this publication and the *Workers' Compensation Act* and/or Board approved policy documents, the *Act* or the approved document governs.

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**Sign  
the  
VR  
plan**

*(See  
page 4)*

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## UN RAPPEL!

À tous ceux qui prennent part à la conception et à l'élaboration du plan de RP – l'agent de RP, le travailleur blessé, l'employeur et, si possible, le médecin traitant.

En apposant votre signature au plan de RP, vous signalez votre contribution et votre engagement à faire en sorte que le plan fonctionne. Il est toujours possible de modifier un plan de RP ou d'en élaborer un nouveau, lorsque les circonstances changent. Dans tous les cas, le plan de RP doit être signé.

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Le Bulletin des politiques est publié par la Direction des politiques sur l'indemnisation de la Commission des accidents du travail. S'il y a contradiction entre les déclarations contenues dans cette publication et la Loi sur les accidents du travail et/ou les politiques approuvées de la Commission, c'est à la Loi ou aux documents approuvés qu'il faut se référer.

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## Il faut signer le plan de RP

UN RAPPEL

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Pour commander, il suffit de remplir le bulletin de commande inséré dans le

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(La version française n'est pas encore disponible.)

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Exemple : Un travailleur temporaire reçoit un salaire régulier de 200 \$ et une indemnité de congé de 50 \$ pour deux semaines de travail. L'employeur calcule la cotisation de la CAT sur le total des gains (250 \$) pour la période de deux semaines.

Cette nouvelle formule remplace la « méthode de conversion » qui était utilisée pour calculer les cotisations de 1988 et de 1989. En vertu de cette méthode, l'indemnité de congé était convertie en un nombre équivalent de jours de travail rémunérés et ces jours s'ajoutaient à la période travaillée. Les employeurs qui ont utilisé la méthode de conversion pendant ces deux années peuvent avoir droit à un rabais. Pour avoir des précisions, communiquez avec la Direction de la vérification des employeurs au (416) 927-3820.

## **(08-04-14, Indemnité de congé et indemnité de départ des travailleurs blessés)**

La Commission a mis à jour ses trois politiques sur la déficience auditive en raison de modifications découlant du projet de loi 162. Les éléments essentiels de ces politiques n'ont pas changé et ils sont conformes au processus-verbal n° 4 du conseil, daté du 3 juin 1988, page 5238.

### **Déficience auditive attribuable au bruit et acouphène**

Les politiques mises à jour sur la déficience auditive attribuable au bruit et l'acouphène ont trait aux demandes d'indemnisation dont la date d'accident n'est pas antérieure au 2 janvier 1990.

Le document 04-03-10 comprend, en plus de directives sur l'admissibilité :

- une description du barème de taux utilisé pour déterminer la déficience permanente (*Guides de l'AMA*);
- une méthode servant à déterminer le niveau en décibel d'une exposition au bruit qui est l'équivalent d'une exposition continue au bruit pendant huit heures par jour, pendant au moins cinq ans;
- une méthode servant à déterminer les indemnités lorsqu'il y a présence de déficience auditive reliée à l'âge, d'un état pathologique préexistant ou d'une exposition hors de la province;
- un tableau comparatif de la procédure à adopter dans le cas des demandes d'indemnisation dont la date d'accident est antérieure ou postérieure au 2 janvier 1990.

La politique révisée sur l'acouphène (04-03-11) explique l'évaluation de la déficience permanente au moyen des *Guides de l'AMA*.

La déficience auditive due au bruit et l'acouphène se manifestent sur une longue période de temps. Une demande d'indemnisation peut être présentée à la Commission de nombreuses années après les premiers symptômes d'une déficience. Les politiques existantes (04-03-06 et 04-03-07) sont conservées dans le manuel des politiques parce que, à l'occasion, il faudra utiliser le barème de taux précédent pour les demandes d'indemnisation antérieures au 2 janvier 1990.

### **Déficience auditive attribuable à un traumatisme**

La politique mise à jour sur la déficience auditive attribuable à un traumatisme (03-03-02) traite des demandes d'indemnisation dont la date d'accident n'est pas antérieure au 2 janvier 1990. La seule modification apportée par rapport à la politique précédente a trait à l'utilisation des *Guides de l'AMA* pour déterminer la déficience permanente. La politique clarifie également les méthodes actuelles servant à déterminer le montant des indemnités lorsqu'il y a état pathologique préexistant ou déficience auditive reliée à l'âge.

**Pf et modification du  
code d'exemption nette  
(suite)**

**Paiement dans le cas  
des rendez-vous  
médicaux non observés  
ou annulés**

**Avances sur  
l'indemnisation par  
l'employeur – pensions  
et suppléments pour  
PEF**

**Retenue automatique  
des aliments versés à la  
famille**

**Indemnité de congé des  
travailleurs temporaires  
et cotisation**

- si la différence entre les deux calculs est égale ou supérieure à 10 %, le travailleur reçoit le nouveau montant.

#### **(05-05-15, PEF : modification du code d'exemption nette, envoi n° 25)**

Depuis le 1<sup>er</sup> janvier 1993, la Commission ne paie pas les frais de rendez-vous médicaux non observés ou annulés par les travailleurs, qu'il s'agisse d'examen, de traitements ou d'évaluations de PNE.

#### **(06-02-02, Frais médicaux, envoi n° 25)**

La Commission retransche des indemnités du travailleur tout montant que l'employeur a versé au travailleur, à titre d'avance, pour l'interruption de travail résultant d'un accident relié au travail.

Par suite d'une révision de politique récente, de telles avances seront également déduites des pensions et des suppléments pour PEF dont le versement a débuté ou s'est poursuivi après le 1<sup>er</sup> juillet 1993. Cependant, ne sont pas assujetties à des déductions relatives aux avances de la part de l'employeur :

- les pensions versées en vertu des *Lois* antérieures à 1989,
- les indemnités pour PNE, et
- les indemnités pour PEF.

#### **(05-01-04, Avances sur l'indemnisation par l'employeur, envoi n° 25)**

La *Loi de 1991 modifiant le Régime des obligations alimentaires envers la famille* exige que des retenues au titre des aliments versés à la famille soient effectuées automatiquement sur les sources de revenu périodiques lorsqu'une ordonnance à cet effet a été prononcée.

Lorsqu'elle reçoit une telle ordonnance ou un avis d'ordonnance de la part du Bureau du Régime des obligations alimentaires envers la famille, la Commission effectue automatiquement les retenues sur les indemnités des travailleurs.

Les indemnités suivantes sont assujetties à la retenue :

- l'arriéré versé dans le cas des indemnités périodiques,
- les indemnités totales temporaires,
- les indemnités partielles temporaires,
- les pensions de déficience partielle permanente (avant 1990),
- les suppléments aux indemnités de déficience partielle permanente en vertu de l'art. 147,
- les suppléments aux indemnités de déficience partielle permanente d'avant le projet de loi 162,
- les indemnités et suppléments pour PEF,
- les indemnités pour PNE payées sous forme de versements périodiques.

Le total de la retenue n'est habituellement pas supérieur à 50 % du montant des indemnités périodiques que la Commission verse au travailleur. Cependant, si le travailleur reçoit également un revenu périodique d'une source autre que la Commission, le montant de la retenue effectuée par la Commission peut être supérieur à 50 %.

#### **(05-01-15, Retenue automatique des aliments versés à la famille)**

Depuis le 1<sup>er</sup> janvier 1988, lorsqu'un employeur calcule la cotisation de la CAT, il considère comme gains toute somme versée à un travailleur temporaire à titre d'indemnité de congé; la somme vient s'ajouter au salaire régulier du travailleur, selon la période de paie réelle travaillée.



## PEF et modification du code d'exemption nette

Si le code d'exemption nette (CEN) d'un travailleur est modifié après la détermination initiale de la PEF, un nouveau calcul est effectué, selon le nouveau CEN, au moment de la révision de la PEF suivante. Si un CEN inexact a été utilisé pour déterminer l'indemnité pour PEF, la Commission refait le calcul en utilisant le CEN exact.

Au moment de la révision de la PEF, l'indemnité pour PEF recalculée, fondée sur le nouveau CEN, est comparée à l'ancien montant et :

- si la différence entre les deux calculs est inférieure à 10 %, aucun changement n'est apporté;

## (01-02-13, Participants aux stages de formation – Directives provisoires)

Le 30 avril 1993, la CAT mettait fin à une deuxième ronde de consultation portant sur le protection à accorder aux participants en stage de formation non rémunérée autorisée par un organisme de formation. Le conseil d'administration a approuvé l'énoncé de politique en principe et a ordonné qu'il entre en vigueur le 1<sup>er</sup> juillet 1993. Cette politique remplace les directives provisoires qui expireront le 30 juin 1993.

La nouvelle politique, comme les directives provisoires, précise que :

- les participants aux stages de formation sont des « stagiaires » en vertu de la définition de « travailleur » et ils sont admissibles à des indemnités lorsqu'ils subissent une lésion pendant qu'ils travaillent pour l'employeur offrant le placement;
- l'employeur chez lequel le participant aux stages de formation est placé en vue d'acquérir l'expérience de travail est l'« employeur »; cet employeur est à l'abri de poursuites civiles si le participant est blessé.

Depuis le 18 février 1993, le gouvernement de l'Ontario paie les coûts d'indemnisation des participants aux stages de formation qui participent à des programmes parrainés par le gouvernement. Des discussions sont en cours entre la Commission et Emploi et Immigration Canada (EIC) au sujet du financement de la protection à accorder aux personnes placées par ce ministère.

## Participants aux stages de formation – énoncé de politique

## (07-03-12, Déménagement des travailleurs blessés en vertu de l'art. 52)

L'article 52 autorise la Commission à payer les frais de déménagement d'un travailleur si le fait de déménager à un nouveau lieu en Ontario aide le travailleur à trouver un emploi permanent. Les frais payés peuvent comprendre certains coûts rattachés au déménagement (transport, résiliation d'un bail, vente de la résidence, etc.)

Les critères suivants doivent être satisfaits avant que les frais de déménagement d'un travailleur ne soient payés :

- le travailleur doit s'être vu offrir un emploi dans le nouveau secteur;
- le nouvel emploi offert ne peut être comblé par aucun autre travailleur blessé résidant déjà dans le nouveau secteur;
- aucune possibilité d'emploi approprié n'existe dans le lieu de résidence régulier du travailleur;
- le travailleur n'est pas admissible au Programme de mobilité de la Commission de l'emploi et de l'immigration du Canada (PMCEIC), ou l'aide dans le cadre du PMCEIC ne couvre pas les frais de déménagement du travailleur;
- la distance entre le domicile du travailleur blessé et le lieu de travail, et la durée des déplacements, sont :
- supérieures à celles qui prévalaient avant l'accident, et
- le trajet est d'au moins 100 km, ou la durée d'au moins deux heures, dans un sens comme dans l'autre.

## Déménagement des travailleurs blessés en vertu de l'art. 52 (suite)

Voici des points importants tirés des politiques nouvelles et révisées en application depuis le 1<sup>er</sup> janvier 1993. Veuillez consulter le Manuel des politiques opérationnelles (PO) pour obtenir le texte intégral des politiques et des directives.

Dans le cadre d'un plan de réadaptation professionnelle (RP), la Commission fournit aux travailleurs qui sont en mesure de chercher activement un travail une aide à la recherche d'emploi pendant une période pouvant atteindre six mois. La Commission peut prolonger cette aide pendant une période supplémentaire de six mois lorsque :

- le degré de déficience du travailleur exige une recherche d'emploi de longue durée;
- le travailleur accepte une modification des objectifs professionnels;
- un changement imprévu survient dans le marché du travail.

Ainsi, après examen de ces directives, si le travailleur n'a toujours pas trouvé d'emploi après six mois et qu'une aide supplémentaire lui est accordée, la recherche d'emploi est axée sur le marché du travail régional et non plus sur le marché du travail local.

### (07-03-09, Aide à la recherche d'emploi)

En décembre 1992, le conseil d'administration a approuvé de nouvelles directives visant à élargir le champ de la recherche d'emploi du travailleur et à le faire passer du marché du travail local au marché du travail régional. Lorsque l'agent de réadaptation professionnelle élabore le plan de RP pour un travailleur, avant la détermination de l'indemnité pour perte économique future (PEF) de celui-ci, il doit fonder les éléments du plan sur les occasions d'emploi qui existent dans le marché du travail local, à moins que le travailleur n'accepte de son plein gré d'effectuer une recherche dans le marché régional ou provincial. Si, avant la première révision de la PEF (au cours du 24<sup>e</sup> mois qui en suit la détermination), les services de RP continuent d'être offerts et que le travailleur n'a pas trouvé d'emploi, l'agent de RP, le travailleur et l'employeur doivent modifier et signer le plan de RP afin d'étendre la recherche d'emploi au marché du travail régional. L'agent de RP modifie le plan avant de transmettre le dossier à l'agent d'indemnisation pour PEF en vue d'une première révision.

### Exceptions

Le plan de RP n'est pas modifié en vue d'axer la recherche sur le marché du travail régional lorsque :

- au moment de la première révision, le travailleur a eu peu de temps pour effectuer une recherche d'emploi à fond dans le marché du travail local;
- le déménagement occasionnerait des difficultés personnelles considérables au travailleur;
- le déménagement aurait un impact négatif significatif sur les perspectives de carrière du conjoint du travailleur;
- le travailleur a atteint un âge où il est convenu, de concert avec la Commission, que le déménagement ne serait pas une solution réaliste.

### (07-02-08, Détermination d'un objectif de RP)

Aide à la recherche d'emploi dans les marchés du travail local et régional

Élargissement des activités de recherche d'emploi au moment de la première révision de la PEF et après celle-ci





# POLICY REPORT

July 1993

Vol. 6 No. 4

## Scleroderma Policy Adopted

Based on the report of the Industrial Disease Standards Panel (IDSP), the Board adopted a new policy dealing with scleroderma on April 1, 1993. The policy states

The WCB recognizes scleroderma resulting from industrial exposure to silica dust as an industrial disease pursuant to subsection 1(1) of the *Workers' Compensation Act*.

### What is scleroderma?

Scleroderma is a rare, chronic disease. Its name means "hardening of the skin" but it can also affect internal organs and is frequently fatal. Also called progressive systemic sclerosis, the clinical course of scleroderma varies from case to case and depends on age, sex, the extent and location of skin disease, and whether internal organs are involved. Body systems that may be affected include the skin, respiratory, cardiovascular, digestive, urinary, and musculoskeletal systems.

The disease is primarily seen in women. However, an unusual number of cases has been observed in hard-rock miners, and other occupations and workplaces where there is substantial exposure to silica dust, such as

- sandblasting
- manufacture of abrasives, grinding and scouring compounds, moulds for castings, fillers for paints and mastic, glass, optical equipment, pottery, ceramics, electronic components, fibreglass, radio and TV components
- brick and cement work
- buffing, metal polishing and grinding
- foundries (ferrous and non-ferrous)
- cutting granite
- quarries
- steel plants
- stone and claymaking.

Other types of work may also expose workers to substantial amounts of silica dust.

In response to a request from a Member of Provincial Parliament, the IDSP conducted an investigation into the possible relationship between scleroderma and occupational exposure to silica. After studying research reports from such places as the United States, Germany, and South Africa, the IDSP reported its findings, and supported the existence of such a relationship.

### Who is eligible?

Substantial levels of exposure to silica dust at work, for workers diagnosed with scleroderma, is considered persuasive evidence that the disease is due to the nature of the work. Claims for workers with short exposure are considered on their own merits, with claims involving high-intensity exposure being considered to have "substantial" exposure. Also, the Board is reconsidering claims that previously were denied compensation for scleroderma.

The new policy is being communicated to employers and workers in the mining community, and rheumatologists and internists are being informed through the Ontario Medical Association. Stakeholders should advise the Board of any claims that they think may be eligible for reconsideration.

### Who pays?

Costs associated with the reconsideration of scleroderma claims are excluded from employers' historical records. They are applied to the class as a whole and charged back to the rate groups within the class.

### Issue to be re-examined

The policy will be reviewed in 1996, or earlier if new information becomes available.

## IDSP

The Industrial Disease Standards Panel (IDSP) was established by the Ontario legislature in 1985, and gets its authority from s.95 of the *Act*.

Its purpose is

- (a) to investigate possible industrial diseases;
- (b) to make findings as to whether a probable connection exists between a disease and an industrial process, trade or occupation in Ontario;
- (c) to create, develop and revise criteria for the evaluation of claims respecting industrial diseases; and
- (d) to advise on eligibility rules regarding compensation for claims respecting industrial diseases. [s.95(8)]

The Panel is made up of a maximum of 9 members including representatives of the public, the scientific community, technical experts, and professionals. Though it reports its findings to the WCB, the Panel acts independently of the Workers' Compensation Board and the Ministry of Labour.

Before accepting or rejecting any findings of the Panel, the Board must publish a notice in *The Ontario Gazette* containing the findings and asking for comments, briefs, and submissions to be filed with the Board within 60 days of the notice (or other specified period). After this period expires, the Board must then publish its reasons for accepting or rejecting the findings in *The Ontario Gazette*.

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## Notice

The IDSP has recently submitted a report to the Board entitled "Report to the Workers' Compensation Board on Respiratory Complication Among Workers Receiving Compensation for Non-malignant Respiratory Disease".

The report was published in *The Ontario Gazette* on May 15, 1993, and the deadline for submissions on this report is August 13, 1993.

Reports are available from:

Industrial Disease Standards Panel  
69 Yonge Street  
Suite 1004  
Toronto, Ontario  
M5E 1K3  
(416) 327-4156

If you would like to provide the Board with comments, briefs, or submissions, send them to:

Ms. Linda Angove  
Secretary to the Board  
Workers' Compensation Board  
2 Bloor Street East  
Toronto, Ontario  
M4W 3C3

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## Did you know...

that medical assessment reports used to calculate non-economic loss (NEL) benefits can also be used to assist in determining entitlement to other benefits and services.

NEL assessment reports are often the most up-to-date medical information on file. Therefore, decision-makers can use NEL assessment reports, along with any other medical information on file, to help determine such things as entitlement to vocational rehabilitation services.

(For more information about NEL benefits see Policy Report Vol. 4 No. 5 and section 05-06 in the OP manual.)

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## Adoption d'une politique sur la sclérodémie (suite)

Qui paye?

Les coûts rattachés au réexamen des demandes d'indemnisation pour sclérodémie sont exclus des résultats des employeurs. Ils sont imputés à la catégorie dans son ensemble, puis réimputés aux groupes de taux de la catégorie.

Révision

La présente politique sera révisée en 1996 ou avant cette date si de nouveaux renseignements surgissent.

## Avis

Le CNMMP a récemment présenté à la Commission un rapport traitant des complications respiratoires chez les travailleurs qui reçoivent des indemnités pour une maladie respiratoire bénigne.

Ce rapport a été publié dans la *Gazette de l'Ontario* le 15 mai 1993; la date limite pour la présentation de mémoires sur ce rapport est le 13 août 1993.

Pour obtenir une copie du rapport, veuillez communiquer avec le :

Comité des normes en matière de maladies professionnelles

Bureau 1004  
69, rue Yonge  
Toronto (Ontario) MSE 1K3  
(416) 327-4156

Si vous avez des commentaires ou un mémoire à ce sujet, veuillez les présenter à :

Mme Linda Angove  
Secrétaire du conseil  
Commission des accidents du travail  
2, rue Bloor Est  
Toronto (Ontario) M4W 3C3

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## Saviez-vous

que...

les rapports d'évaluation médicale utilisés lors du calcul de l'indemnité pour perte non économique (PNE) peuvent également être utilisés pour déterminer l'admissibilité à d'autres indemnités et services?

Les rapports d'évaluation pour PNE renferment souvent les renseignements médicaux les plus à jour dans un dossier. Les décideurs peuvent donc utiliser les rapports d'évaluation pour PNE, ainsi que les autres renseignements médicaux contenus dans le dossier, pour déterminer, par exemple, l'admissibilité aux services de réadaptation professionnelle.

(Pour obtenir plus de précisions sur l'indemnité pour PNE, voir le Bulletin des politiques, Vol. 4, N° 5, ainsi que la section 05-06 du Manuel des politiques opérationnelles.)

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## CNMMP

Le Comité des normes en matière de maladies professionnelles (CNMMP) a été établi par l'Assemblée législative de l'Ontario en 1985. Il tire son autorité de l'article 95 de la Loi.

Le Comité a pour mission :

- d'étudier les maladies professionnelles éventuelles;
- d'établir s'il existe un rapport probable entre une maladie et un procédé, une profession ou un métier donné dans une industrie en Ontario;
- d'élaborer, de mettre au point et de réviser les critères d'évaluation des demandes d'indemnité en ce qui concerne les maladies professionnelles; et
- d'offrir des conseils sur les règles d'admissibilité pour ce qui est des indemnités relatives aux demandes ayant trait à des maladies professionnelles.

[Par. 95 (8)]

Le Comité se compose d'au plus neuf membres, y compris des représentants du public, des professions libérales et des communautés scientifiques et techniques. Même s'il doit soumettre ses constatations à la CAT, le Comité est indépendant de la Commission des accidents du travail et du ministère du Travail.

Avant d'accepter ou de rejeter les conclusions du Comité, la Commission doit publier dans la *Gazette de l'Ontario* un avis énonçant les conclusions et invitant le dépôt, auprès d'elle, d'observations et de mémoires dans les soixante jours qui suivent la publication de l'avis ou au cours d'une période plus longue. À l'expiration du délai prévu, la Commission doit publier dans la *Gazette de l'Ontario* ses raisons à l'appui de l'acceptation ou du refus des conclusions.

Le *Bulletin des politiques* est imprimé sur du papier recyclé, exempt d'acide, et ce, sans frais supplémentaires.



## Adoption d'une politique sur la sclérodémie

- le découpage du granit,
  - la préparation de l'argile et le travail de la pierre,
  - le travail du ciment et de la brique,
  - le travail dans les fonderies (métaux ferreux et non ferreux),
  - le travail dans les carrières,
  - le travail dans les sidérurgies.
- D'autres genres de travaux peuvent également comporter l'exposition à de fortes concentrations de poussière de silice.

En réponse à la demande d'un député provincial, le CNMMP a mené une enquête pour étudier le lien possible entre la sclérodémie et l'exposition au silice en milieu de travail. Après avoir étudié les conclusions de rapports en provenance des États-Unis, de l'Allemagne et de l'Afrique du Sud, le CNMMP a publié son propre rapport et reconnu l'existence d'un tel lien.

### Qui est admissible?

Chez les travailleurs reconnus comme atteints de sclérodémie, une exposition importante à la poussière de silice au travail est considérée comme la preuve concluante que la maladie est attribuable à la nature du travail. Dans le cas des travailleurs soumis à une faible exposition, les demandes sont considérées au mérite, et la Commission estime que les travailleurs soumis à une exposition de forte intensité ont eu une exposition «importante». De plus, la Commission reconside les demandes d'indemnisation pour sclérodémie antérieurement rejetées. La nouvelle politique est communiquée actuellement aux travailleurs et aux employeurs du secteur minier, les rhumatologues et les internes seront informés par l'entremise de l'Association médicale de l'Ontario. Les personnes et groupes intéressés devraient aviser la Commission de toute demande qui, à leur avis, devrait être reconsidérée.

(suite au verso)

Compte tenu du rapport du Comité des normes en matière de maladies professionnelles (CNMMP), la Commission a adopté, le 1<sup>er</sup> avril 1993, une nouvelle politique traitant de la sclérodémie.

### Qu'est-ce que la sclérodémie?

La sclérodémie est une maladie chronique rare. Le nom signifie «durcissement de la peau»; la maladie peut atteindre les organes internes et elle est souvent mortelle. Aussi connue sous le nom de sclérose systémique progressive, la sclérodémie se manifeste de différentes façons, selon l'âge et le sexe de la personne atteinte, l'étendue et la localisation de l'affection cutanée et la possibilité d'une atteinte des organes internes. La maladie peut toucher la peau ainsi que les systèmes respiratoire, cardio-vasculaire, digestif, urinaire et musculo-squelettique.

Cette maladie se manifeste surtout chez la femme. Cependant, un nombre inhabituel de cas ont été observés chez les travailleurs des mines de minerai dur et d'autres professions et lieux de travail comportant une exposition importante à la poussière de silice dont :

- le dépolissage au sable,
- la fabrication d'abrasifs, de pâtes à roder et à découper, de moules, de blancs de charge pour la peinture et le mastic, de vitres, de matériel optique, de poteries, de céramiques, de composantes électroniques, de fibre de verre, de composantes de radio et de télévision,
- le bufflage, le polissage et le meulage des métaux,



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# POLICY REPORT



Workers'  
Compensation  
Board

Commission  
des accidents  
du travail

September 1993  
Vol. 6 No. 5

## Unpaid Training Participants



Every year in Ontario, over 100,000 people are involved in unpaid work placements to gain work experience. Of concern to these individuals and employers alike is the question of workers' compensation coverage in the event of an accident. Are these people covered? Are the employers they are placed with protected from civil liability? And, if there is coverage, who funds it?

Following two rounds of external consultation, new policies and guidelines covering individuals on unpaid work placements were implemented effective July 1, 1993.

### Policy

Individuals who are placed by training agencies with employers to obtain work skills and experience, but who are not paid by the employer, are "learners". The "employer" of these individuals is the employer with whom they are placed.

Section 1 of the *Workers' Compensation Act* (the *Act*) defines a worker as a person who has entered into or is employed under a contract of service or apprenticeship, written or oral, express or implied, including learners – individuals who, although **not under a contract of service or apprenticeship**, become subject to the hazards of an industry for the purpose of undergoing training or probationary work specified or stipulated by the employer as a preliminary to employment.

Under the new policy, training participants are "learners" if:

- the placement is authorized by a training agency, and
- the individual participates, however minimally, in the activities of the placement employer's industry, including job shadowing and
- they are not paid by the employer. (Social assistance benefits, training allowances, honoraria, reimbursement expenses, or any money paid to the training participant by a training agency are not considered pay.)

### Learners include

- college or university students on a training placement with an employer as a formal part of their course or program, e.g.,
  - nursing students on placement with a hospital
  - law and security students on placement with a police force
  - social work students on placement with a social service agency
- individuals placed with an employer by a private vocational school as part of their course or program
- individuals placed with an employer by a municipality or a provincial or federal government ministry or agency or a community or social agency to obtain work skills and experience
- individuals placed with an employer by a private rehabilitation agency or by the rehabilitation department of an insurer
- Ontario residents enrolled in an out-of-province training program who do the placement portion of the program with an Ontario employer covered by the *Act*
- non-Ontario residents enrolled in an out-of-province training program who do the placement portion of their program in Ontario with an employer covered under the *Act* (subject to the provisions of *Operational Policy* (OP) manual document 01-02-11).

Workers' compensation coverage extends only to the job placement portion of the training program. There is no coverage for in-class portions of training programs.

### Employer

The employer with whom the worker is placed to gain work experience – not the training agency – is the "employer".

### Employers with no workers

If operators in an industry covered by the *Act* normally employ no workers, but become employers only because they take on a training participant, they and the training participant are protected under the *Act*.

In such cases, no penalty is charged against the employer for not registering with the Board.

### *Temporary disability benefits*

- Training participants are entitled to temporary disability benefits for as long as the injury continues, and it prevents them from taking part in the training program.

Injured training participants continue to take part in training programs if their placement duties are modified to accommodate their injuries.

In the case of a college, university, or private vocational school student, such placements are considered modified if the training agency excuses the participant from completing that portion of the placement, with no negative consequences for the training participant.

If the placement is not modified to accommodate the training participant, the participant may still continue with the in-class portion of the training program, if it is still available.

- Training participants are entitled to temporary disability benefits for as long as the injury continues, and if the program is no longer available, the injury prevents the participant from taking part fully in the labour force.

A training program is considered no longer available if:

- the training program has ended

OR

- in the case of college or university students, it is summer break.

If the training participant is capable of suitable work that pays less than the pre-injury earnings, partial temporary disability benefits are paid.

If the training participant is totally disabled from working, temporary total disability benefits are paid.

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### *Calculating temporary total disability rate*

For accidents on or after July 1, 1993, the Board calculates training participants' benefits based on the amount the employer paid full-time workers in the same trade that the training participant was training in when injured. The decision-maker uses the starting salary of a full-time worker in the same position with the employer. If the employer does not have a full-time worker in that position, the decision-maker uses the salary for that position with other employers in the same locality.

If the work performed by the training participant was unique and not performed by any other worker, either with the employer or with other employers in the locality, the decision-maker looks to a similar job with the employer, or, if this is not practicable, to a similar job with other employers in the locality. To determine what is a suitable similar job, the decision-maker considers the skill, aptitudes, and level of education the learner will have upon completing the training program.

Note: Stakeholders indicated that they believe the regulation does not accurately reflect the real loss of earning capacity experienced by learners. Therefore, the WCB is reviewing the Regulation.

### *Entitlement to re-employment*

For accidents on or after July 1, 1993, if a training participant has been on an unpaid placement with an employer for 12 continuous months, the employer must offer the training participant the same placement opportunity as before the injury. The injury does not create an obligation for the employer to offer the training participant a regular, full-time job.

For training participants on unpaid placements, "12 continuous months" means a single, uninterrupted placement with the same employer. Uninterrupted placements of less than a year with different employers, even though the total placement time adds up to more than a year, do not create an obligation for the employer. Similarly, a series of interrupted placements amounting to a year or more with the same employer do not create an obligation.



## Funding

### Government-funded programs

The Ontario government or Employment and Immigration Canada (EIC) may pay the accident costs of training participants injured on unpaid placements with employers. There are very few situations where the Ontario government or EIC does not pay costs. (For confirmation that costs in a particular program are funded, contact the Training Agency.)

If either the Ontario government or EIC **does** pay the costs, the training agency – not the employer – must submit

- a Form 7 (Employer's Report of Injury/Disease) to the Board whenever a training participant has a placement-related injury.

*(See OP manual document 02-02-03 and s.133 of the Act.)*

- a letter to the Board from the employer designating the Ontario government, EIC, or the training agency as the employer's representative. This letter is essential to permit the training agency to handle the claim on behalf of the employer.

*(See OP manual document 01-04-12 – Authorization of Representatives.)*

If the Ontario government or EIC is paying the accident costs, they also pay any late filing charges levied under s.133 of the *Act*.

When costs are government funded, Schedule 1 employers are not required to pay any assessments with respect to the training participant, and any accident costs involving the participant do not affect the employer's experience rating. Similarly, no claims costs or administrative fees are charged to Schedule 2 employers.

### Programs not Government-funded

If there is a program that is not funded by the Ontario government or EIC, Schedule 1 employers are not required to pay assessments for their unpaid training participants who are on placement with them. However, a placement-related injury may affect the employer's standing in experience rating.

Schedule 2 employers are responsible for all accident costs of training participants in programs not under the Ontario government or EIC funding umbrella.

## Training participants who are not learners

The following individuals on unpaid placements are **not** learners under this policy:

- individuals who, on their own initiative, volunteer their services to an employer to develop marketable work skills
- volunteers who offer their time or services for community or charitable purposes
- individuals in health care or correctional institutions who do unpaid work as a part of therapy or correction
- individuals placed with an employer under a Community Service Order issued by a court of law
- individuals who are on the employer's premises **only** for the purposes of visiting or casual observation, and who at no time participate in the activities of the placement employer's industry
- university and college students who as part of their program do unpaid research for the university or college
- individuals who are not on placement but who, as part of the training program, do work on the training agency's premises
- Ontario residents in an Ontario training program who do the placement portion of their program with an out-of-province employer.

## Ministry of Education and Training programs

For workers' compensation purposes, under the *Education Act* the Ministry of Education and Training, and not the employer the student is placed with, is the employer of students in the following work education programs:

- Supervised Alternative Learning for Excused Pupils (SALEP)
- School Workplace Apprenticeship Program (SSWAP) prior to becoming registered apprentices
- Secondary school co-op programs
- Job-shadowing programs for students over 14 years of age.

These students are "workers" and not learners.

## **EIC section 25 job creation program**

Individuals placed with an employer as part of a job creation program through Employment and Immigration Canada (EIC) under the s.25 Unemployment Insurance Job Creation Program are “workers” who are paid for the work they perform. If they are injured while working for the employer, any accident costs may affect the employer’s standing in experience rating.

## **Laid-off apprentices on unpaid placement**

Laid-off apprentices who continue to train through an unpaid placement with an employer are “**apprentices**” (see OP manual document 01-02-08), but they are covered by the Ontario government funding umbrella. Therefore, their employers are not responsible for any workers’ compensation costs.

## **Placement employer not covered by Act**

Training participants are not covered if they are placed with employers that are not required to be covered under the *Act* and that have not obtained coverage by application.

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### Employeurs offrant le placement non couverts par la Loi

Les participants aux stages de formation placés chez un employeur qui n'est pas obligatoirement couvert par la Loi et qui n'a pas obtenu la protection facultative ne sont pas protégés en vertu du régime d'indemnisation.

### Apprentis participant à un stage non rémunéré mis à pied

Les apprentis ayant été mis à pied qui poursuivent leur formation par le biais d'un stage non rémunéré chez un employeur sont des «*apprentis*» (voir le document 01-02-08 du Manuel des politiques opérationnelles). Ils sont cependant sous l'égide financière du gouvernement de l'Ontario et leur employeur n'est pas responsable des coûts d'indemnisation engagés à leur endroit.

### Programme de création d'emploi Art. 25 de la Loi sur l'assurance-chômage

Les particuliers placés chez un employeur dans le cadre d'un programme de création d'emploi offert par Emploi et Immigration Canada (EIC) en vertu de l'article 25 portant sur le programme de création d'emploi de la Loi sur l'assurance-chômage sont des «*travailleurs*» rémunérés pour le travail qu'ils exécutent. Si ces participants sont blessés pendant qu'ils sont au service de l'employeur, les coûts d'accidents engagés peuvent influencer sur les résultats de l'employeur en matière de tarification par incidence.

**Veuillez adresser vos questions ou commentaires à la :**

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## Participants qui ne sont pas stagiaires

- Dans le cadre de la présente politique, les participants suivants qui prennent part à des placements non rémunérés ne sont **pas** stagiaires :
- les participants qui, de leur propre initiative, offrent bénévolement leurs services à un employeur, en vue d'acquiescer des compétences professionnelles monnayables;
  - les bénévoles qui offrent leur temps ou leurs services à la communauté ou à une oeuvre de charité;
  - les participants travaillant dans des établissements de santé ou des instituts correctionnels et qui effectuent un travail non rémunéré dans le cadre d'une thérapie ou d'un programme correctionnel;
  - les participants placés chez un employeur en vertu d'une ordonnance de service communautaire émise par un tribunal;
  - les participants qui se trouvent sur les lieux de travail d'un employeur **uniquement** dans le but de visiter ces lieux ou d'en observer les activités, et qui ne participent en aucun temps aux activités de l'industrie de l'employeur offrant le placement;
  - les étudiants des niveaux collégial ou universitaire qui, dans le cadre de leur programme d'études, effectuent une recherche non rémunérée pour le collège ou l'université;
  - les particuliers qui, sans être en stage, effectuent un travail sur les lieux de l'organisme de formation, dans le cadre de leur programme de formation;
  - les résidents de l'Ontario inscrits à un programme de formation prévu à leur programme chez un employeur hors de la province.

## Programmes du ministère de l'Éducation et de la Formation

- Aux fins de l'indemnisation des travailleurs, en vertu de la *Loi sur l'éducation*, l'employeur des élèves participant aux programmes de travail-études suivants est le ministère de l'Éducation et de la Formation et non l'employeur chez lequel l'élève est placé :
- Programme d'apprentissage parallèle dirigé pour les élèves dispensés de fréquentation scolaire
  - Programme d'apprentissage combiné aux cours dans les écoles secondaires (ACCES), avant que les élèves ne deviennent des apprentis inscrits
  - Programme d'alternance travail-études
  - Programme d'observation au poste de travail, pour les élèves qui ont plus de 14 ans.
- Ces élèves sont des «travailleurs» et non des stagiaires.

## Financement

### Programmes financés par le gouvernement

- Dans le cadre des programmes qu'ils offrent, le gouvernement de l'Ontario et Emploi et Immigration Canada (EIC) peuvent payer les coûts d'accidents rattachés aux lésions que subissent les participants pendant qu'ils participent à un stage de formation non rémunéré chez un employeur. Il existe très peu de cas où le gouvernement de l'Ontario et Emploi et Immigration Canada (EIC) n'assurent pas de tels coûts. (Pour vous assurer que les coûts d'accidents sont payés dans le cadre d'un programme particulier, veuillez communiquer avec l'organisme de formation.)
- Lorsque le gouvernement de l'Ontario ou Emploi et Immigration Canada (EIC) paye les coûts d'accidents, il appartient à l'organisme de formation – et non à l'employeur – de soumettre à la Commission :
- un formulaire 7, Avis de lésion ou de maladie (employeur), chaque fois qu'un participant à un stage de formation subit une lésion reliée au placement;
- (Voir le document 02-02-03 du Manuel des politiques opérationnelles et l'article 133 de la Loi.)
- une lettre de l'employeur offrant le placement indiquant que le gouvernement de l'Ontario, EIC ou l'organisme de formation est son représentant. Une telle lettre est essentielle pour permettre à l'organisme de formation de traiter la demande d'indemnisation au nom de l'employeur.
- (Voir le document 01-04-12, «Autorisation des représentants», du Manuel des politiques opérationnelles.)
- Si le gouvernement de l'Ontario ou EIC paye les coûts d'accidents, ils doivent également payer toute amende pour déclaration en retard, tel qu'il est prévu à l'article 133 de la Loi.
- Lorsque les coûts sont assumés par le gouvernement, les employeurs de l'annexe 1 ne sont pas tenus de payer de cotisation pour les participants aux stages de formation qu'ils accueillent et qui sont engagés dans des programmes de formation non financés par le gouvernement de l'Ontario ou Emploi et Immigration Canada. Les coûts rattachés aux lésions reliées au placement peuvent toutefois influencer sur les résultats de l'employeur en matière de tarification par incidence. De même, les coûts d'indemnisation ou les frais administratifs ne sont pas imputés aux employeurs de l'annexe 2.

### Programmes non financés par le gouvernement

Les employeurs de l'annexe 2 assument tous les coûts d'accidents reliés aux lésions subies par les participants aux stages de formation qu'ils accueillent et qui sont engagés dans des programmes non financés par le gouvernement de l'Ontario ou d'Emploi et Immigration Canada.



## Indemnités d'invalidité temporaire

■ Les participants aux stages de formation ont droit à des indemnités d'invalidité temporaire tant que leur lésion les empêche de prendre part au programme de formation.

Les participants aux stages de formation continuent de prendre part à un programme de formation si les tâches devant être accomplies dans le cadre de leur placement sont modifiées en fonction de la lésion que ceux-ci ont subie.

Si un étudiant est inscrit à un programme offert par un collège, une université ou une école de métiers privée, le placement sera considéré comme étant modifié si l'organisme de formation permet au participant de se retirer du placement prévu au programme, sans effet défavorable pour le participant lui-même.

Si le placement n'est pas modifié de sorte à répondre aux besoins du participant, celui-ci peut poursuivre la partie du programme de formation donnée en classe, si elle est toujours offerte.

■ Les participants aux stages de formation ont droit à des indemnités d'invalidité temporaire tant que leur lésion les empêche de prendre part au programme de formation, et si le programme n'est plus disponible, de réintégrer pleinement le marché du travail.

Un programme de formation n'est plus considéré comme disponible :

- s'il a pris fin;
- OU

- dans le cas des étudiants de niveau collégial et universitaire, au moment du congé d'été.

Des indemnités d'invalidité partielle temporaire sont versées lorsque le participant est capable d'effectuer un travail modifié dont le salaire est inférieur à celui qu'il touchait avant la lésion.

Des indemnités d'invalidité totale temporaire sont versées si le participant est atteint d'une invalidité totale l'empêchant de travailler.



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## Calcul des indemnités d'invalidité totale temporaire

Pour les accidents survenus le 1<sup>er</sup> juillet 1993 ou après cette date, la Commission calcule les indemnités d'un participant à un stage de formation en se basant sur le salaire de départ que l'employeur versait à un travailleur à plein temps occupant le même poste que celui dans lequel était placé le participant lorsqu'il a été blessé. Si l'employeur offrait le placement n'a pas de travailleur à plein temps occupant le même poste que le participant, le décideur se base sur le salaire de départ d'un travailleur occupant le même poste chez d'autres employeurs de la même ville.

Si le travail effectué par le participant est unique et qu'il ne soit effectué par aucun autre travailleur ni auprès de l'employeur offrant le placement ni auprès d'autres employeurs de la même ville, le décideur tente de trouver un emploi similaire chez l'employeur offrant le placement, ou, si cela s'avère impossible, un emploi similaire chez d'autres employeurs de la même ville. Lorsqu'il détermine ce qui constitue un emploi similaire approprié, le décideur tient compte des compétences, des aptitudes et du niveau de scolarité que possèdera le stagiaire au terme du programme de formation.

Remarque : Les personnes et groupes intéressés étant d'avis que le règlement ne traduit pas fidèlement la diminution réelle de capacité de gain des stagiaires, la CAT réexamine donc cette question.

## Droit au renforcement

Pour les accidents survenus le 1<sup>er</sup> juillet 1993 ou après cette date, si un participant à un stage de formation non rémunéré a été placé chez un employeur pendant douze mois consécutifs, l'employeur offrant le placement doit offrir au participant le même placement qu'avant la lésion. L'employeur offrant le placement n'est pas tenu d'offrir au participant qui a subi une lésion un emploi régulier à plein temps.

Dans le cas des participants en stage de formation non rémunérés, l'expression «douze mois consécutifs» signifie un seul placement ininterrompu chez un seul employeur. Les placements ininterrompus de moins d'un an chez différents employeurs, même si la durée totale de ces placements est de plus d'un an, n'imposent pas une obligation de renforcement à l'employeur offrant le placement. De même, une série de placements interrompus totalisant un an ou plus chez le même employeur n'assujettit pas l'employeur offrant le placement à une obligation de renforcement.



## Participants aux stages de formation non rémunérés

Chaque année en Ontario, plus de 100 000 personnes font l'objet d'un placement non rémunéré dans le but d'acquérir une expérience de travail. La question de la protection prévue par le régime d'indemnisation des travailleurs en cas d'accident revêt une importance particulière tant pour ces personnes que pour les employeurs. Ces personnes sont-elles protégées par le régime d'indemnisation? Les employeurs qui les accueillent sont-ils à l'abri de poursuites judiciaires? Et si la protection est offerte, qui en paie les coûts? Après deux séries de consultations externes, la Commission a mis en oeuvre, le 1<sup>er</sup> juillet 1993, de nouvelles politiques et directives sur les participants en stage de formation non rémunéré.

### Politique

Les particuliers qui sont placés chez des employeurs par des organismes de formation dans le but d'acquérir des compétences et une expérience de travail, mais qui ne sont pas rémunérés par les employeurs, sont des «stagiaires». L'employeur chez lequel ces particuliers sont placés est l'«employeur» de ceux-ci.

L'article 1 de la Loi sur les accidents du travail (la Loi) définit le travailleur comme quiconque a passé un contrat de louage de services ou d'apprentissage, écrit ou verbal, expresse ou implicite, y compris le stagiaire — soit celui qui, bien que n'étant pas lié par un contrat de louage de services ou d'apprentissage, est exposé aux risques d'une industrie dans le cadre d'un travail de formation ou d'essai précisé ou stipulé par l'employeur comme préalable à l'emploi.

En vertu de la nouvelle politique, les participants aux stages de formation sont des «stagiaires» lorsque les conditions suivantes sont satisfaites :

- le placement est autorisé par un organisme de formation;
- le particulier prend part, même de façon minime, aux activités de l'industrie de l'employeur offrant le placement, y compris l'observation au poste de travail;
- le participant n'est pas payé par l'employeur. (Les prestations d'aide sociale, les allocations de formation, les honoraires, les dépenses remboursées ou les sommes d'argent versées aux participants par les organismes de formation ne sont pas considérées comme salaire).

### Stagiaires

Les stagiaires comprennent :

- les étudiants des niveaux collégial ou universitaire qui, dans le cadre de leur programme d'études, effectuent un stage de formation auprès d'un employeur, par ex. : les étudiants en sciences infirmières placés auprès d'un hôpital
- les étudiants en administration de la loi et de la sécurité placés auprès d'un corps policier
- les étudiants en sciences sociales placés auprès d'un organisme de service social;
- les particuliers placés chez un employeur dans le cadre d'un programme ou d'un cours offert par une école de métiers privée;
- les particuliers placés chez un employeur soit par une municipalité, soit par un ministère ou un organisme du gouvernement provincial ou fédéral, ou encore par un organisme social ou communautaire, en vue d'acquérir des compétences et une expérience de travail;
- les particuliers placés chez un employeur par un organisme de réadaptation privé ou par le service de réadaptation d'un assureur;
- les résidents de l'Ontario inscrits à des programmes de formation hors de la province, et dont le placement prévu au programme est effectué auprès d'un employeur ontarien couvert par la Loi;
- les non-résidents de l'Ontario inscrits à des programmes de formation hors de la province, et dont le placement prévu au programme est effectué en Ontario auprès d'un employeur couvert par la Loi (sous réserve des dispositions du document 01-02-11 du Manuel des politiques opérationnelles).

### Employeur

Est réputé «employeur», l'employeur chez lequel un particulier est placé dans le but d'acquérir une expérience de travail, et non pas l'organisme de formation.

### Employeurs sans travailleurs

Si un exploitant qui fait partie d'une industrie couverte par la Loi n'emploie normalement pas de travailleurs, mais qu'il devienne employeur seulement du fait qu'il accueille un participant à un stage de formation, l'employeur et le participant jouissent de la protection offerte par la Loi. En de telles circonstances, l'employeur ne se verra imposer aucune amende pour ne pas s'être inscrit auprès de la Commission.



# POLICY REPORT



Workers'  
Compensation  
Board

Commission  
des accidents  
du travail

November 1993  
Vol. 6 No. 6

## The Social Contract — Impact on workers' benefits

Approximately 900,000\* employees of the public sector in the province of Ontario are affected by the *Social Contract*, or by provisions of agreements reached with their employers.

The social contract is in force for 3 years—June 14, 1993 to April 1, 1996 (s.58 of Bill 48). In a significant number of cases—depending on negotiations carried out between workers and employers—the social contract reduces wages by reducing hours of work, e.g., a day off work each month without pay.

*How do such reductions affect workers' compensation benefits?*

### Accidents before social contract reductions

Workers' compensation benefits are based on earnings at the time of the accident [s.40 (1)(a)]. Therefore, benefits paid to workers injured **before** the social contract came into effect would be based on their pre-social-contract earnings. Social contract reduction of hours or wages that occurred while workers were off work recovering from their injuries does not change workers' benefits.

#### Example

**Jerome** was working 40 hours a week, earning \$16 an hour, when he was injured. While Jerome was still away from work the social contract took effect and workers at his workplace were required to take one day off each month without pay, thus reducing their work week to an average of 38 hours.

**Q.** Are Jerome's benefits reduced to reflect the decreased hours worked?

**A.** No. Because the accident happened **before** the social contract came into effect, Jerome's benefits were based on his average earnings at the time of the accident. Once determined, average earnings are not adjusted to reflect any reductions in wages or hours at the workplace.

\*Social Contract Secretariat.

### Accidents after social contract reductions

If a worker is injured **after** social contract reductions in pay or hours of work, the worker's average earnings for the purpose of calculating benefits are based on the (new) wage and hours.

#### Example 1

**P.K.** was earning \$16 an hour and working 40 hours per week before the social contract came into effect. **After** the social contract, his wage remained at \$16, but he had to take 1 day off each month without pay. On one of his 5-day work weeks, he was injured.

**Q.** How were P.K.'s average earnings determined?

**A.** The employer reported P.K.'s earnings at \$16 per hour and reported the new **weekly average hours**—3 weeks at 40 hours and 1 week at 32, for an average of 38 hours a week. This is exactly as it should be. It is the average hours worked that counts. Whether the injury happens during a regular 5-day work week or during a 4-day week it does not matter.

#### Example 2

**Penny's** work-related injury also occurred after the social contract was negotiated. She, too, had her hours of work reduced, but Penny and her workmates were paid on a weekly basis so her employer averaged their weekly hours over a month and reduced the weekly wage relative to the hours. Penny's employer simply reported Penny's **new** weekly wage on the Form 7, and her workers' compensation benefits were calculated accordingly.

For purposes of Bill 48—"An Act to encourage negotiated settlements in the public sector..." the Ontario public sector is divided as follows:

- The Ontario Public Service Sector
- The Health Sector
- The Community Services Sector
- The Schools Sector
- The Colleges Sector
- The Universities Sector
- The Agencies, Boards and Commissions Sector
- The Municipalities Sector.



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## Modified work and Temporary Partial Difference (T.P. Diff.) benefits

When partially disabled workers return to light duties at a reduced rate of pay, the Board pays 90% of the difference between their light-duty pay and their pre-accident pay. This benefit is referred to simply as “T.P. Diff.”

- Q. How do you calculate the T.P. Diff. benefits if the accident happened **before** the social contract, and the worker returns to light duties **after** the social contract?
- A. Don't let the social contract cloud the issue. The formula for calculating T.P. Diff. benefits is always the same:

$$\text{T.P. Diff} = 90\% (\text{Pre-injury earnings} - \text{post-injury earnings})$$

T.P. Diff. benefits end when the worker is capable of doing the pre-injury job.

## Comparable work

When an injured worker is fit to return to the essential duties of the pre-injury job, and the re-employment obligations (s.54) apply, the employer must either

- reinstate the worker in the position held on the day of the injury, or
- offer other work that is comparable in nature and earnings to the pre-injury job. This means that the new wage must not be less than 90% of the current earnings of the pre-injury job (see OP manual document 07-05-09).

## Example

**Dominique** and **Tom** were both injured before the social contract came into effect. But, during their absence from work, the social contract was legislated and their average work-weeks were reduced from 40 hours to 38 hours.

## -POLICY REPORT-

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Now, they are both ready to return to work. Dominique returns to her pre-injury job. Tom is returning to a different job that satisfies all criteria of comparable work except that it pays \$1.50 per hour less than his job at the time of the accident.

- Q. Do Dominique's pre-injury job and Tom's new job satisfy the s.54 obligation, since both these jobs entail fewer hours of work because of the social contract?
- A. Yes. Dominique is returning to her pre-injury job and the wages currently associated with it—even though the hours have been reduced by the social contract.
- A. Yes. Tom's new job meets all the criteria of comparable work, including wages which exceed 90% of the wages associated with his pre-injury job.

1) pre-injury wage: \$16 x 40 hours per week	= \$640
2) pre-injury wage after social contract: 16 x 38	= \$608
3) 90% of \$608	= \$547.20
4) comparable job: \$14.50 x 38	= \$551

## Recurrences

If workers have recurrences of their injuries—no matter if the recurrence is before or after social contract reductions—benefits are always calculated on whichever is higher—the earnings at the time of the accident or earnings at the recurrence.

## Advances paid by employers

Some employers pay their injured workers “advances” (OP manual 05-01-04) on compensation benefits. If the worker receives an advance less than 90% of net average earnings, the Board reimburses the employer the advance, and pays the difference directly to the worker. If the worker receives an advance equal to or more than 90% of net, the Board reimburses the employer only 90% of net.

- Q. What happens when employers paid advances **before** the social contract, and then reduced the advances because of the social contract?
- A. Although the social contract reduced the wages—as reflected in the advances—such a reduction has **no** effect on the worker's rate of compensation. The worker's rate of compensation is still based on 90% of the pre-social contract earnings. The WCB reimburses the employer the advance, and if the advance is less than the compensation rate, pays the difference directly to the worker. ☐



## Travail modifié et complètement salarial temporaire (CST)

Lorsqu'un travailleur partiellement invalide entreprend un travail léger dont le salaire est inférieur à celui qu'il touchait avant sa lésion, la Commission lui verse 90 % de la différence entre le salaire d'avant la lésion et le salaire rattaché à ce nouveau travail. Ce genre d'indemnité s'appelle «complètement salarial temporaire».

Q. Comment la Commission calcule-t-elle le complètement salarial temporaire d'un travailleur si celui-ci a subi un accident avant l'entrée en vigueur du contrat social et qu'il entreprend un travail léger après l'entrée en vigueur du contrat social?

R. En pareil cas, les dispositions du contrat social n'entrent aucunement en ligne de compte. La formule servant au calcul du complètement salarial temporaire est toujours la même :

$$\text{CST} = 90\% \text{ de (gains avant la lésion - gains après la lésion)}$$

Le versement du complètement salarial temporaire prend fin lorsque le travailleur est en mesure d'effectuer son travail d'avant la lésion.

## Travail comparable

Lorsqu'un travailleur blessé est en mesure de s'acquitter des tâches essentielles de l'emploi qu'il occupait avant la lésion et que les obligations de rengagement aux termes du paragraphe 54 de la Loi sur les accidents du travail s'appliquent, l'employeur doit :

- rengager le travailleur au poste qu'il occupait à la date où la lésion est survenue; ou

- offrir au travailleur un autre emploi, de nature et aux gains comparables à ceux de l'emploi d'avant la lésion. Ainsi, le nouveau salaire ne doit pas être inférieur à 90 % des gains actuellement rattachés à l'emploi d'avant la lésion (voir le document 07-05-09 du Manuel des politiques opérationnelles).

## Exemple

Chantal et Bruno ont tous deux subi une lésion avant l'entrée en vigueur du contrat social. Pendant leur interruption de travail, le contrat social a eu force de loi, et la moyenne de leurs heures de travail hebdomadaires est passée de 40 à 38 heures.

## BULLETIN DES POLITIQUES

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## Veillez adresser vos questions ou commentaires à la :

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Présentement, ces deux travailleurs sont en mesure de retourner au travail. Chantal reprendra son emploi d'avant la lésion. Toutefois, Bruno entreprendra un travail qui respecte tous les critères relatifs au travail comparable, sauf en ce qui a trait à la rémunération. En effet, il touchera 1,50 \$ l'heure de moins dans le cadre de ce nouveau travail comparativement au salaire qui lui était versé au moment de l'accident.

Q. Est-ce que l'emploi qu'occupait Chantal avant sa lésion et le nouvel emploi de Bruno respectent les obligations prévues à l'article 54 de la Loi, étant donné que le nombre d'heures de travail rattachées à ces deux emplois ont été réduites en raison du contrat social?

R. Oui. Chantal reprendra son emploi d'avant la lésion et touchera le salaire actuellement associé à cet emploi, bien que ses heures de travail aient été réduites en vertu du contrat social.

R. Oui. Le nouvel emploi de Bruno satisfait aux critères relatifs à un travail comparable, et le salaire qui y est associé dépasse 90 % du salaire d'avant la lésion :

1) salaire d'avant la lésion : 16 \$ x 40 heures	= 640,00 \$
2) salaire d'avant la lésion mais après l'entrée en vigueur du contrat social : 16 \$ x 38	= 608,00 \$
3) 90 % de 608,00 \$	= 547,20 \$
4) travail comparable : 14,50 \$ x 38	= 551,00 \$

## Récidives

Si un travailleur subit une récursive de sa lésion, que ce soit avant ou après l'entrée en vigueur du contrat social, ses indemnités sont calculées en fonction de ses gains au moment de la lésion initiale ou de ses gains au moment de la récursive, toujours selon le plus élevé de ces deux montants.

## Avances versées par les employeurs

Certains employeurs versent des avances (voir document 05-01-04 du Manuel des politiques opérationnelles) à leurs travailleurs blessés. Si un travailleur reçoit de son employeur une avance qui équivaut à moins de 90 % des gains moyens nets, la Commission rembourse cette avance à l'employeur et verse la différence directement au travailleur. Par contre, si le travailleur touche une avance qui est égale ou supérieure à 90 % de ses gains moyens nets, la Commission ne rembourse à l'employeur qu'un montant correspondant à 90 % des gains moyens nets du travailleur.

Q. Qu'arrive-t-il lorsqu'un employeur a versé à un travailleur des avances avant l'adoption du contrat social et qu'il réduit le montant de ces avances en raison de l'entrée en vigueur du contrat social?

R. Même si, en vertu du contrat social, les salaires ont été réduits, ce qui se traduit nécessairement par une réduction des avances, de telles réductions n'ont aucune incidence sur le taux d'indemnisation. Le taux d'indemnisation d'un travailleur correspond toujours à 90 % des gains d'avant le contrat social. Ainsi, la Commission rembourse à l'employeur l'avance qu'il a consentie et, si cette avance est inférieure au taux d'indemnisation, elle verse la différence directement

au travailleur. □

## Le contrat social – Son incidence sur l'indemnisation des travailleurs

### Accidents survenus après les réductions prévues par le contrat social

Si un travailleur se blesse après que les réductions relatives aux salaires ou aux heures de travail prévues par le contrat social ont été imposées, les gains moyens du travailleur servant au calcul des indemnités sont alors établis en tenant compte de son nouveau salaire et de ses nouvelles heures de travail.

#### Exemple 1

Pierre touchait 16 \$ l'heure et travaillait 40 heures par semaine avant l'entrée en vigueur du contrat social. Après que le contrat social a pris effet, Pierre a continué de gagner 16 \$ l'heure, mais il s'est vu obliger de prendre un jour de congé non rémunéré par mois. Dans le cadre d'une de ses semaines de travail de 5 jours, il a subi une lésion.

Q. Comment les gains moyens de Pierre ont-ils été établis?

R. L'employeur a déclaré à la Commission que Pierre gagnait 16 \$ l'heure et indiquait la moyenne de ses nouvelles heures de travail hebdomadaires. Comme Pierre travaillait trois semaines à raison de 40 heures et une semaine à raison de 32 heures, cette moyenne était de 38 heures par semaine. En effet, c'est de la moyenne des heures travaillées dont il faut tenir compte. Il importe peu que le travailleur ait subi une lésion au cours d'une semaine de travail de 4 jours ou de 5 jours.

#### Exemple 2

Joanne a également subi une lésion reliée au travail après la négociation du contrat social. Tout comme Pierre, elle s'est vu imposer une réduction de ses heures de travail. Comme Joanne et ses collègues étaient payés chaque semaine, leur employeur a établi la moyenne des heures de travail hebdomadaires qu'ils effectuaient sur une période d'un mois et réduit leur salaire hebdomadaire en tenant compte de cette moyenne. Ainsi, l'employeur n'a eu qu'à déclarer sur le formulaire 7 le nouveau salaire hebdomadaire que Joanne touchait, et les indemnités auxquelles celle-ci a eu droit ont été calculées en conséquence.

Environ 900 000\* employés du secteur public de l'Ontario sont touchés par le contrat social ou par les dispositions prévues dans les accords qu'ils ont conclus avec leurs employeurs.

Le contrat social est en vigueur pendant trois ans, soit du 14 juin 1993 au 1<sup>er</sup> avril 1996 (art. 58 du projet de loi 48). Dans bon nombre de cas, selon les accords négociés entre travailleurs et employeurs, le contrat social prévoit une réduction des salaires en diminuant le nombre d'heures de travail, par exemple, en imposant un jour de congé non rémunéré par mois.

Quelle incidence de telles réductions ont-elles sur l'indemnisation des travailleurs?

### Accidents survenus avant les réductions prévues par le contrat social

Les indemnités versées aux travailleurs sont calculées en fonction des gains que ceux-ci touchaient au moment de l'accident [al. 40 (1) a) de la Loi sur les accidents du travail]. Ainsi, les indemnités payées à un travailleur qui s'est blessé avant l'entrée en vigueur du contrat social sont basées sur ses gains d'avant le contrat social. Toute réduction des heures de travail ou des salaires, prévue par le contrat social, qui a été imposée pendant que le travailleur s'est absenté du travail pour se rétablir de sa lésion n'a aucune incidence sur les indemnités qu'il reçoit de la Commission.

#### Exemple

Jérôme travaillait 40 heures par semaine et touchait 16 \$ l'heure lorsqu'il a subi une lésion. Il n'avait toujours pas repris le travail au moment où le contrat social a pris effet. En vertu du contrat social, les travailleurs du secteur pour lequel Jérôme travaillait se sont vu imposer un jour de congé non rémunéré tous les mois, leur semaine de travail étant ainsi réduite à une moyenne de 38 heures.

Q. Les indemnités que reçoit Jérôme devront-elles être rajustées à la baisse pour tenir compte de la réduction des heures de travail?

R. Non. Étant donné que l'accident est survenu avant l'entrée en vigueur du contrat social, les indemnités de Jérôme ont été calculées en fonction des gains moyens qu'il touchait au moment de l'accident. Une fois établis, les gains moyens d'un travailleur ne peuvent être rajustés pour tenir compte d'une réduction des salaires ou des heures de travail survenant dans le lieu de travail du travailleur.



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# POLICY REPORT

Workers'  
Compensation  
Board

Commission  
des accidents  
du travail

December 1993  
Vol. 6 No. 7

## New Form 6 and 7 in 1994

*In every case of  
work-related injury or  
disease that disables a  
worker from earning full  
wages, or results in a  
worker requiring health  
care, it is mandatory  
that the employer's  
report be submitted  
within 3 calendar days  
using a standard  
"Employer's Report of  
Injury/Disease – Form  
7", or pre-approved  
employer-created  
version of the form  
(Operational Policy  
(OP) manual  
02-02-03).*

On May 28, 1993, the WCB's Board of Directors approved two revised forms: the **Worker's Report of Injury/Disease – Form 6** and the **Employer's Report of Injury/Disease – Form 7**. Effective January 1, 1994, the WCB will use the revised forms to register claims and determine entitlement to compensation benefits.

After consultation with its internal and external clients throughout 1991 and 1992, the WCB redesigned the forms to be user-friendly and to meet increased information requirements. As reported in Policy Report, Vol. 4 No. 8, the new Form 7 was pre-tested using London-area claims in the first 3 months of 1992.

In 1994, employers reporting injuries/diseases will be asked to provide a copy of the completed Form 7 to their injured workers. And, upon request, the WCB will provide employers with copies of the worker's Form 6. The purpose of exchanging information is to help identify issues early in the life of a claim, thereby reducing the number of objections or appeals later on. In turn, improved claims administration will allow for more timely decision-making, better service delivery, and long-term cost savings.

### Employer's Report of Injury/Disease Form 7

The Form 7 must be completed whenever an employer learns a work-related injury or disease has caused a worker to

- be absent from regular work (lose time)
- earn less than regular pay
- assume lighter duties
- obtain health care.

It is **not** necessary for employers to file a report when they administer first aid only. However, Regulation 1101 of the *Workers' Compensation Act* (the *Act*) requires that a record be kept of all first aid care.

The WCB allows up to 7 working days from the date an employer learns of an accident or the onset of an industrial disease to receive the employer's report. Working days are Monday to Friday, except statutory holidays. The report may be delivered by

- FAX
- hand or courier
- regular mail.

If any of the information requested on the employer's report is not immediately available, employers should send the information they have, and submit the rest as soon as possible, since under s.133 the WCB can fine employers \$250.00 for late submission of Form 7s.



Form 7s are supplied free to all employers. They are available in English and French. Regional offices of the Workers' Compensation Board have copies of the form with the appropriate return address at the top.

The WCB has sent a supply of new Form 7s to employers in a mass mailing this fall. To obtain additional Form 7s, employers can complete and send in the reorder request form contained in the package.

All pre-approved computer generated Form 7s currently in use will be invalid at the end of 1993. Employers wishing to continue using their own computer-generated Form 7s must send their version of the new form to the WCB for pre-approval. Prior approval must be obtained from the executive director of the integrated service unit handling the employer's claims.

The new Form 7 has a 2-page vertical format, with instructions and reporting obligations printed on the reverse of the employer's copy. There are 3 copies of each page—the 1st copy for the WCB, the 2nd for the worker, and the 3rd for the employer.

After completing and signing the Form 7, employers send the top copy (white) to the WCB, give the 2nd copy (pink) to the worker, and keep the 3rd copy (yellow) for their records.

The form now has more space for reporting details of injuries/diseases, and when properly completed, contains all of the information required to set up a claim. However, employers may still attach a letter to provide additional information.

See the enclosed insert for more detailed information about the new Form 7 and an illustrated example.

## **Worker's Report of Injury/Disease Form 6**

The WCB sends a Form 6 to workers when lost-time claims are registered, or when additional information is required from workers to make a decision on entitlement to compensation. The Form 6 allows workers to

- describe their injury/disease
- provide information on health care, earnings, and employment benefits.

Although the Form 6 is not always essential for determining initial entitlement, the WCB's decision-making capacity is enhanced when a Form 6 is on file. Detailed answers to questions on the Form 6 allow decision-makers to define, very early in the claim, the worker's anticipated vocational rehabilitation needs.

Failure to return the completed form could delay compensation and other benefits, and the worker's right to consideration for vocational rehabilitation services (OP manual 02-02-02). However, if the nature of the injury/disease temporarily prevents the worker from completing the Form 6, it is obtained as soon as the worker is able to complete it.

The new Form 6 requests more detailed information from injured workers about their injury or disease. The enclosed insert shows an illustrated example.

*Under s.22 of the Act,  
workers must report a  
work-related injury or  
disease, as soon as  
possible, to their  
employers and the  
WCB.*



Le formulaire 7 est fourni gratuitement à tous les employeurs. Il est disponible en version anglaise ou française. Les bureaux régionaux de la CAT ont des exemplaires du formulaire dont l'adresse de retour appropriée est indiquée au haut.

Cet automne, la CAT a fait parvenir à grande échelle une provision du nouveau formulaire 7 aux employeurs. Pour en obtenir des exemplaires supplémentaires, les employeurs devront utiliser le bon de commande qui leur sera fourni.

À la fin de 1993, tous les formulaires 7 produits par ordinateur et approuvés par la CAT, en usage actuellement, ne seront plus valables. Les employeurs qui désirent continuer à utiliser leur propre formulaire 7 produit par ordinateur doivent soumettre leur version du nouveau formulaire à l'approbation de la CAT. Une telle approbation doit être obtenue du directeur général de l'Unité de services intégrés qui traite les demandes d'indemnisation de l'employeur.

Le nouveau formulaire 7 est de format vertical et il comporte deux pages; les instructions et les obligations de déclaration paraissent au verso de la copie de l'employeur. Chaque page comporte trois copies : la première est destinée à la CAT, la deuxième au travailleur et la troisième, à l'employeur.

Après avoir rempli et signé le formulaire 7, les employeurs envoient la copie du dessus (blanche) à la CAT, remettent la deuxième (rose) au travailleur et conservent la troisième copie (jaune) pour leurs dossiers.

Comme il offre plus d'espace pour l'insertion des détails concernant les lésions et les maladies, le formulaire, lorsqu'il est convenablement rempli, renferme tous les renseignements requis pour l'établissement d'un dossier. Les employeurs peuvent toujours joindre une lettre pour donner plus de renseignements.

Pour plus de précisions, voir l'encart ci-joint et le formulaire 7 modèle.

## **Avis de lésion ou de maladie (travailleur)**

### **Formulaire 6**

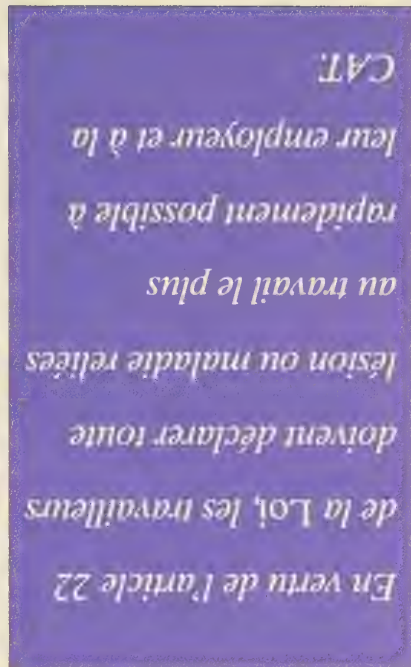
La CAT envoie le formulaire 6 aux travailleurs lorsqu'une demande d'indemnisation pour interruption de travail est présentée ou lorsque la Commission a besoin de renseignements supplémentaires pour rendre une décision sur le droit aux indemnités. Le formulaire 6 permet au travailleur de :

- décrire sa lésion ou sa maladie;
- fournir des renseignements sur les soins médicaux, les gains et les avantages rattachés à l'emploi.

Même si le formulaire 6 n'est pas toujours nécessaire à la détermination de l'admissibilité initiale, le fait qu'il soit versé au dossier aide la CAT dans sa prise de décision. Les réponses détaillées aux questions posées dans le formulaire 6 permettent aux décideurs d'établir, très tôt dans le processus, quels sont les besoins du travailleur en matière de réadaptation professionnelle.

Le fait de négliger de retourner le formulaire pourrait retarder le versement des indemnités et nuire au droit que possède le travailleur d'être considéré pour les services de réadaptation professionnelle (politique 02-02-02). Toutefois, si la nature de la lésion ou de la maladie empêche temporairement le travailleur de remplir le formulaire, on lui demande de le remplir dès qu'il est en mesure de le faire.

Le nouveau formulaire 6 exige des travailleurs qu'ils fournissent des renseignements plus détaillés sur la lésion ou la maladie. L'encart ci-joint en donne un exemple pratique.



## Formulaires 6 et 7 : du nouveau pour 1994

Chaque fois que survient une lésion ou une maladie reliées au travail qui empêchent un travailleur de gagner son plein salaire ou l'oblige à recevoir des soins médicaux, l'employeur doit, dans les trois jours civils qui suivent, déclarer l'incident en utilisant l'Avis de lésion ou de maladie (employeur) – Formulaire 7, ou une version de ce formulaire, autorisée au préalable et préparée par l'employeur.

(Politique 02-02-03)

### Avis de lésion ou de maladie (employeur)

Le 28 mai 1993, le conseil d'administration de la Commission des accidents du travail (CAT) approuvait les révisions apportées au formulaire 6 «Avis de lésion ou de maladie (travailleur)» et au formulaire 7 «Avis de lésion ou de maladie (employeur)». Le 1<sup>er</sup> janvier 1994, la CAT commencera à utiliser les formulaires révisés pour enregistrer les demandes d'indemnisation et déterminer l'admissibilité du travailleur aux indemnités.

Après avoir consulté ses clients internes et externes en 1991 et 1992, la CAT a remodifié ces formulaires pour les rendre plus faciles à utiliser et satisfaisant à de nouvelles exigences en matière d'information. Comme il a été annoncé dans le numéro de décembre 1991, le nouveau formulaire 7 a été mis à l'essai dans la région de London pendant les trois premiers mois de 1992.

Les employeurs qui déclareront des lésions ou des maladies en 1994 seront invités à remettre aux travailleurs blessés une copie du formulaire 7 rempli. De plus, la CAT remettra, sur demande, des exemplaires des formulaires 6 aux employeurs. Cet échange d'information vise à aider à préciser les points litigieux tôt dans le processus d'indemnisation et à réduire le nombre des contestations et des appels ultérieurs. En améliorant ainsi la gestion des demandes d'indemnisation, l'on pourra parvenir à une prise de décisions en temps plus opportun, à une meilleure prestation de services et à la réalisation d'économies à long terme.

Le formulaire 7 doit être rempli chaque fois qu'un employeur apprend qu'un travailleur a subi une lésion reliée au travail ou contracté une maladie professionnelle qui l'oblige à :

- s'absenter de son travail régulier;
- gagner un salaire moins élevé que son salaire normal;
- accomplir des tâches légères;
- recevoir des soins médicaux.

L'employeur n'a pas à remplir le formulaire lorsque seuls des premiers soins sont donnés. Toutefois, le Règlement 1101 de la Loi sur les accidents du travail (la Loi) exige que l'on inscrive dans un registre tous les premiers soins prodigués.

Pour la réception des avis, la CAT permet un délai de sept jours ouvrables entre le moment où un employeur apprend qu'une lésion est survenue ou qu'une maladie est apparue et la réception de l'avis. Les jours ouvrables vont du lundi au vendredi, à l'exception des jours fériés. Les avis peuvent être acheminés :

- par télécopieur,
- en main propre ou par messagerie,
- par la poste.

S'ils ne disposent pas immédiatement de tous les renseignements demandés dans le formulaire, les employeurs devraient transmettre ceux qu'ils ont et envoyer le reste dans les plus brefs délais. En vertu de l'article 133 de la Loi, la CAT peut imposer une amende de 250,00 \$ en cas d'avis présenté en retard.



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# Policy Report



Workers'  
Compensation  
Board

Commission  
des accidents  
du travail

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## Average earnings of apprentices, learners, and students

Section 14 of *Regulation 1102* describes how the WCB arrives at the average earnings of workers who are apprentices, learners, and students. Following external consultation and a policy review, the regulation was amended with respect to **learners** injured on or after December 16, 1993.

To calculate temporary disability benefits **before** the amendment, the WCB used the starting salary of the job for which learners were being trained. But a majority of the consultation participants felt that many learners' income losses were less than the starting salary. Thus the regulation was changed to more closely match learners' real income losses.

The following **summarizes** how the WCB now arrives at the average earnings of apprentices, learners, and students.

### Apprentices

The WCB determines the average earnings of apprentices by using the average earnings of workers who finished their apprenticeship (journeypersons) and who worked for the same employer in the same trade when the apprentice was injured.

If employers had no journeypersons in the same trade when the apprentice was injured, the WCB determines average earnings by using the average wage of journeypersons who worked in the employer's locality in the same trade at the time of the injury.

### Learners

When calculating **temporary disability benefits**, the WCB now determines the average earnings of workers who are learners by

- using the total income—received at the time of their injuries—that ends when

workers' compensation benefits begin. Such income includes training allowances, social assistance benefits, insurance benefits, and unemployment insurance.

- using the Ontario minimum wage at the time of the injury if they have no income when they are injured
- applying the WCB's concurrent employment policy (05-02-05) when learners have wages at the time of the injury from work performed concurrently with training, if they have not accepted an offer of employment
- using the starting salary of a job accepted to begin at the end of training.

When calculating **future loss of earnings**, the WCB determines the average earnings of learners by

- using the average earnings of workers who are employed by the same employer in the same trade as the learner at the time of the learner's injury
- using the average wage of a worker employed in the same trade in the employer's locality, at the time of injury, if the employer did not have any workers in the same trade when the learner was injured
- using the average earnings of workers who were employed by the employer or other local employers in a job that is most similar (analogous) to the learner's job at the time of the injury, if there were no workers employed in the trade locally.

continued on page 3

## No-fault auto insurance affects the Act

Throughout this article we refer simply to workers. However, in the case of a worker's death, the worker's spouse and/or dependants may also choose to claim benefits under the *Insurance Act*\* or the *Workers' Compensation Act (WCA)*.

Bill 164, which came into effect on January 1, 1994, contains amendments to the *Insurance Act* and other legislation, including the *WCA*. The *Insurance Act* established no-fault motor vehicle accident insurance.

The *WCA* allows that if workers are in a work-related motor vehicle accident that entitles them to legal action against a person (third party) other than the employer or another worker, the workers can either claim workers' compensation benefits or sue the third party.\*\* This section of the *WCA* (10(1)) remains unchanged.

Now, with Bill 164 in place, workers can choose (elect) to claim benefits

1) under the *Insurance Act*, in which case they can also pursue legal action against the third party for non-pecuniary damages (pain and suffering)

or

2) under the *WCA*.



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continued on page 4

# New nasal cancer policy

Nasal cancer is a rare disease. In the past 10 years, an average of 41 cases a year have been diagnosed in Ontario males.<sup>1</sup> Almost all known causes are occupational, the exceptions being related to the inhalation of snuff and the diagnostic radioisotope injection of the nasal cavities.

The WCB approved a policy on lung and sinus (nasal) cancer in 1981. However, new scientific information generated a policy review—including external consultation—on the issues of both nasal and lung cancer in the nickel-producing industry. The revised policy on lung cancer is not yet complete, but the policy on nasal cancer officially went into effect on December 16, 1993. This was the date that the amendments to *Regulation 1102* under the *Workers' Compensation Act*, adding nasal cancer to the schedules, were filed by the Lieutenant-Governor-in-Council.

## Policy

Primary cancer of the nasal cavities and the paranasal sinuses are industrial diseases characteristic of processes, trades or occupations in the nickel-producing industry.

If a worker is diagnosed with primary cancer of the nasal cavities or paranasal sinuses and was employed in the nickel-producing industry at or before the date of disablement from the disease, entitlement is considered under Schedule 4 or Schedule 3 of the *Act*, or on a case-by-case basis.

## Nickel-producing industry

International scientific studies have identified certain activities in the nickel-producing industry as substantially increasing the risk of a worker developing primary nasal or paranasal sinus cancer. If a worker is diagnosed with either of these cancers after being employed in

- any process in INCO Limited's Copper Cliff sinter plant as practiced at any time or

- any process in INCO Limited's Leaching, Calcining and Sintering Department at Port Colborne as practiced prior to Jan. 1, 1966,

it is likely that the disease is work-related, and the worker is automatically entitled to compensation.

If a worker is diagnosed with primary nasal or paranasal sinus cancer after being employed in a concentrating, smelting, or refining process in the nickel-producing industry, the disease is deemed to be due to the nature of the employment, unless the contrary is proved. Additionally, policy guidelines state that the processes carried out in the electrolytic tankhouse at the Port Colborne Nickel Refinery are considered refining processes.

Usually, the latency for nasal and paranasal sinus cancer is 15 years or more. "Latency" is the amount of time between the date of first employment in the workplace and the date that the disease is diagnosed. If a worker meets the criteria in column 1 and column 2 of Schedule 3 and has a latency of 15 years or more, in most cases, no further evidence is required.

However, if a worker meets the criteria in column 1 and column 2 of Schedule 3, but has a latency of less than 15 years, other factors must be considered before deciding that the contrary has been proved. (See accompanying article on page 3.)

In each claim for primary nasal or paranasal sinus cancer, the worker's full job history is examined, because nickel workers often work in more than one process and, therefore, may have had more than one type of exposure. Even those working in mining, transportation, offices or warehouses, or maintenance and cleaning services may have had significant exposure in other parts of the nickel-producing industry.

## Other industries

Almost all causes of nasal and paranasal sinus cancer are occupational. Therefore, if it is determined that the worker's nasal

or paranasal sinus cancer was not due to the nature of employment in concentrating, smelting or refining in the nickel-producing industry, the disease may still be due to workplace causes.

Other well-established occupational causes of the disease include

- woodworking (especially among machinists, carpenters, joiners, sawyers, turners or spindle moulders) in the furniture and cabinet-making industry
- boot and shoe manufacture and repair
- isopropyl alcohol manufacture
- mustard gas production
- radium dial painting.

As new scientific information becomes available, other processes or industries may be recognized as increasing workers' risk of developing nasal cancer.

Every claim the WCB receives for nasal cancer is adjudicated on its own merits.

For details about this policy, watch for document 04-04-01 in the next update to the Operational Policy manual.

<sup>1</sup> According to the Ontario Cancer Treatment and Research Foundation

## Policy Report

**Policy Report** is published under the authority and direction of the Benefits Policy Branch of the Workers' Compensation Board. If there is any conflict between the statements contained in this publication and the *Workers' Compensation Act* and/or Board approved policy documents, the *Act* or the approved document governs.

**Comments or inquiries should be addressed to:**

Editor

**Policy Report**

Benefits Policy Branch  
Workers' Compensation Board  
2 Bloor Street East, 22nd Floor  
Toronto, Ontario M4W 3C3



# Schedules 3 and 4

If workers develop a work-related industrial disease, they or their dependants are entitled to compensation under the *Act*. To help in the adjudication of certain industrial disease claims, Schedule 3 and Schedule 4 were created by the Ontario Legislature.

Each schedule consists of 2 columns. Column 1 lists or describes the disease, and column 2 lists the type of work involved (process). To add new entries to the schedules, *Regulation 1102* under the *Workers' Compensation Act* must be amended by a legislative committee and receive final approval of the Lieutenant-Governor-in-Council.

Schedule 3 of *Regulation 1102* of the Revised Regulations of Ontario, 1990, was amended on December 16, 1993, by adding the following items:

Column 1	Column 2
Description of Disease	Process
16. Primary cancer of the nasal cavities or of paranasal sinuses	Concentrating, smelting or refining in the nickel-producing industry.

In Schedule 3, if you are diagnosed with the disease in column 1 **and** you were employed in the process in column 2, it is presumed that the disease is due to the nature of the employment —“unless the contrary is proved.”

In Schedule 4, the same presumption of work-relatedness is given to workers who meet the criteria in column 1 and column 2, except that there is no clause stating “unless the contrary is proved.” This means that if a worker meets the criteria in column 1 (disease) and 2 (process), the disease is automatically considered to be work-related, and the claim is accepted. (In legal jargon, it is said that there is an irrebuttable presumption that the disease is due to the nature of the employment.)

Schedule 4 of the Regulation was amended on December 16, 1993, by adding the following items:

Column 1	Column 2
Description of Disease	Process
3. Primary cancer of the nasal cavities or of paranasal sinuses	Any process at the Copper Cliff sinter plant of Inco Limited.
4. Primary cancer of the nasal cavities or of paranasal sinuses	Any process in the Port Colborne leaching, calcining and sintering department of Inco Limited that was practiced before January 1, 1966.

There are now sixteen entries in Schedule 3, and four in Schedule 4. For more information about the recent amendments (used in the examples here), see the accompanying article on page 2.

## Average earnings...

*continued from page 1*

In this case the Board also considers the level of education, aptitude, and skills the learner would likely have upon completion of training.

### Students

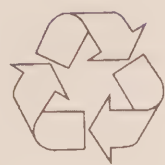
The WCB determines the average earnings of students as the **greater** of

- the weekly rate of pay
- or
- the average earnings of workers employed in a job that the student would likely be employed in on the earlier of
  - the date on which the student is no longer impaired
  - the date on which the student would likely have become a regular full-time worker if the injury had not happened.

In this case, the WCB determines the average earnings of students based on the average industrial wage for the year of the injury, and the students' level of education, aptitude, and skills at the time of the injury.

See the Operational Policy manual for details.

Policy Report is printed on acid-free, recycled paper at no extra cost.



## No-fault auto insurance...

continued from page 1

This choice is called an election, and workers sign an election form to document their choice.

Here are the highlights of the changes to the *Insurance Act* and the *WCA*.

- If workers choose to claim benefits under the *Insurance Act*, they may be entitled to weekly benefits for income loss, plus whatever they can recover in a lawsuit (to the extent allowed under the law).
- If workers decide to claim workers' compensation benefits rather than pursue legal action and benefits under the *Insurance Act*, the WCB has the right to sue the third party for pain and suffering damages.
- If workers elect to claim insurance benefits under the *Insurance Act* and then find that they are not entitled, they can claim workers' compensation benefits.
- Workers who receive workers' compensation benefits and then later get benefits under the *Insurance Act*, are not entitled to any further benefits from the WCB. However, they are not required to repay the workers' compensation benefits they got before they received the *Insurance Act* benefits.
- If workers elect to receive workers' compensation benefits, they must confirm their election (sign another election form) before the WCB can pay NEL or FEL benefits. Workers cannot change their minds once they have confirmed their election.

- In the case of a worker's death, the worker's spouse or dependant child must also confirm the election of workers' compensation benefits before the WCB can pay lump-sum payments under s.35 of the *WCA*. Again, spouses or dependant children cannot change their minds once the election is confirmed.

Board staff who receive workers' compensation claims that involve motor vehicle accidents refer these claims to the Legal Branch immediately so that election forms can be sent out.

Policies which outline these legislative changes and guide WCB decision-makers are currently being developed.

\* The *Insurance Statute Law Amendment Act, 1993*

\*\*The rules are slightly different if the employer is in Schedule 2.

### Dear Subscriber,

The demand for *Policy Report* has grown from a subscriber list of 3,000 in 1988 to 12,000 in 1993. We're glad that this newsletter has proven to be so popular. Many of you who represent workers and employers have used it for your training and information seminars. We hope you will continue to do so for—although it is difficult to quantify—having the right information improves service delivery and saves money.

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As another cost-saving measure, we will not publish an index for *Policy Report* as we have done in the past, although we have prepared it. So, if you save *Policy Report* and want a copy of the index, let us know and we'll send it to you.

From the staff of Policy Publications, we wish you a happy, healthy, and prosperous year.

Jean d'Agenais  
Managing Editor, *Policy Report*

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Designed to meet the information requirements of a broad audience, this manual has proven to be a valuable information system linking Board administrators, decision-makers, and public stakeholders alike to such matters of policy and law as

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- decision-making; wage loss benefits
- industrial diseases
- vocational rehabilitation; re-employment
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Documents reference the legislative authority and/or minute for each policy. Forms, used by workers, employers, and medical and health care practitioners in their communications with the Board, are illustrated. Every 4-5 weeks, new and revised policies are mailed to manual subscribers in shrink-wrapped packages with instructions for their insertion and for the deletion of old documents.

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The lexicon is the official compilation of WCB terminology. The new expanded version includes over 2,000 terms with explanatory notes and medical abbreviations, allowing Board personnel and external stakeholders to communicate more effectively in both official languages. For easy reference, the lexicon is divided into 2 sections: English-French and French-English. The terms in both sections are in alphabetical order.

## **The Employer Classification (EC) manual**

This manual contains

- descriptions of the over 840 Rate Group sub-divisions into which employers are classified
- an introduction which explains the classification scheme and the guidelines for classifying and assessing employers
- a comprehensive alpha-subject index of the Rate Group sub-divisions and a rate group table.

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*continued on page 6*

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*continued from page 5*

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# 1994 facts and figures

	1992	1993	1994
Indexing factor	4.4%	1.6%	1.9%

Earnings ceilings for injuries/diseases occurring	1992	1993	1994
before Apr. 1, '85 (pre-1985 Act)	\$37,700	\$38,400	\$39,200
Apr. 1, '85 to Jan. 1, '90 inclusive (pre-1989 Act)	42,200	42,900	43,800
Jan. 2, '90 to Dec. 31, '90 inclusive (1990 Act)	42,200	42,900	43,800
Jan. 1, '91 to Dec. 31, '91 inclusive	43,900	44,700	45,600
Jan. 1, '92 to Dec. 31, '92 inclusive*	50,800	51,700	52,700
Jan. 1, '93 to Dec. 31, '93 inclusive		52,500	53,500
Jan. 1, '94 to Dec. 31, '94 inclusive			53,900

\* From Jan. 1, 1992 and on, the earnings ceiling is based on 175% of the average industrial wage rounded up to the nearest \$100.

Annual indexed dollar amounts	1992	1993	1994
survivors' lump sum	\$53,075.99	\$53,925.21	\$54,949.79
survivors' adjustment factor	1,326.90	1,348.13	1,373.74
NEL base amount	49,235.00	50,022.76	50,973.19
NEL adjustment factor	1,094.11	1,111.50	1,132.62

Late filing charge	1992	1993	1994
	\$250	\$250	\$250

Post-judgement interest rate	Quarter			
	1st	2nd	3rd	4th
1990	14%	15%	15%	14%
1991	14%	11%	11%	10%
1992	9%	9%	8%	7%
1993	10%	8%	7%	6%
1994	6%			

# 1994 : Quelques chiffres

Facteur d'indexation	1992	1993	1994
	4,4 %	1,6 %	1,9 %

Plafond des gains dans le cas des lésions ou maladies survenues :	1992	1993	1994
---	------	------	------

Avant le 1 <sup>er</sup> avril 1985	37 700 \$	38 400 \$	39 200 \$
(Loi d'avant 1985)			
Entre le 1 <sup>er</sup> avril 1985	42 200	42 900	43 800
et le 1 <sup>er</sup> janvier 1990 inclus (Loi d'avant 1989)			
Entre le 2 <sup>e</sup> janvier et le	42 200	42 900	43 800
31 décembre 1990 inclus (Loi de 1990)			
Entre le 1 <sup>er</sup> janvier et le	43 900	44 700	45 600
31 décembre 1991 inclus			
Entre le 1 <sup>er</sup> janvier et le	50 800	51 700	52 700
31 décembre 1992 inclus*			
Entre le 1 <sup>er</sup> janvier et le		52 500	53 500
31 décembre 1993 inclus			
Entre le 1 <sup>er</sup> janvier et le			53 900
31 décembre 1994 inclus			

\*Depuis le 1<sup>er</sup> janvier 1992, le plafond des gains est basé sur 175 % du salaire moyen dans l'industrie, arrondi au 100 \$ près.

Montants annuels après indexation	1992	1993	1994
Montant forfaitaire, survivants	53 075,99 \$	53 925,21 \$	54 949,79 \$
Facteur de rajustement, survivants	1 326,90	1 348,13	1 373,74
Montant de base PNE	49 235,00	50 022,76	50 973,19
Facteur de rajustement PNE	1 094,11	1 111,50	1 132,62

Amende pour état en retard	1992	1993	1994
	250 \$	250 \$	250 \$

Taux d'intérêt postérieur au jugement	1 <sup>er</sup> trimestre	2 <sup>e</sup> trimestre	3 <sup>e</sup> trimestre	4 <sup>e</sup> trimestre
1990	14 %	15 %	15 %	14 %
1991	14 %	11 %	11 %	10 %
1992	9 %	9 %	8 %	7 %
1993	10 %	8 %	7 %	6 %
1994	6 %			



# Spécialiste de l'indemnisation...

suite de la page 5

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**Le Bulletin des politiques** est envoyé automatiquement aux abonnés du manuel. Le bulletin décrit les politiques nouvelles, révisées ou proposées, et il traite également des questions d'ordre général. Les invitations à participer à des consultations portant sur d'importants énoncés de politique paraissent dans cette publication.

**Remarque** - La version française du *Manuel des politiques opérationnelles* et du *Manuel de classification des employeurs* sera en vente au cours du deuxième semestre de 1994.

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# À L'ATTENTION DES SPÉCIALISTES DE L'INDEMNISATION DES TRAVAILLEURS

**La CAT vous offre ses publications sur les politiques.**

## **Manuel des politiques opérationnelles (PO)**

Conçu pour répondre aux besoins d'un vaste public en matière d'information, le manuel des PO est devenu un outil précieux pour les administrateurs, les décideurs et les divers groupes d'intérêt de la Commission, en ce qui concerne les questions de droit et de politique portant sur les sujets suivants :

- les personnes couvertes par la loi, la présentation des demandes d'indemnisation, la classification des demandes;
- les liens de causalité avec le travail, les accidents, les invalidités, les récidives d'invalidité, les états secondaires;
- la prise de décision, les indemnités pour perte de salaire;
- les maladies professionnelles;
- la réadaptation professionnelle, le renforcement;
- la protection des employeurs, les comptes, les cotisations, la tarification par incidence;
- les appels et les audiences.

Les documents renvoient aux articles de loi et aux procès-verbaux applicables pour chaque politique. Le manuel contient des illustrations des formules qu'utilisent les travailleurs, les employeurs, ainsi que les professionnels de la santé et les praticiens lorsqu'ils communiquent avec la Commission. Toutes les 4 ou 5 semaines, le texte des politiques nouvelles et des politiques révisées, accompagné d'instructions pour l'ajout des nouveaux documents ou le retrait des anciens, est envoyé aux abonnés dans des emballages plastifiés.

## **Lexique bilingue de la CAT (deuxième édition)**

Le lexique renferme la terminologie officielle en usage à la CAT. La nouvelle édition, plus complète, renferme plus de 2 000 entrées accompagnées de notes explicatives et d'abréviations médicales; cet ouvrage permet aux membres du personnel de la Commission et aux groupes d'intérêt externes de communiquer de manière efficace dans les deux langues officielles. Pour une utilisation plus facile, le lexique est divisé en deux sections, anglais-français et français-anglais, et les termes sont disposés par ordre alphabétique.

## **Manuel de classification des employeurs**

Le manuel renferme :

- une description des quelque 840 sous-groupes de groupes de taux dans lesquels les employés;
- une introduction qui explique le mode de classification et qui énonce les directives sur la classification
- des employeurs et la détermination de leurs cotisations;
- un index alphabétique complet sur les sous-groupes de groupes de taux et un tableau des groupes de taux.

Chaque trimestre, le texte des documents nouveaux et des documents révisés est envoyé aux abonnés dans des emballages plastifiés, accompagné d'instructions pour l'ajout ou le retrait de documents.

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# L'assurance auto...

1 suite de la page

Voici les principales modifications apportées à la Loi sur les assurances et à la LAT :

- Si le travailleur choisit de demander les indemnités prévues par la Loi sur les assurances, il peut avoir droit à des indemnités hebdomadaires pour perte de revenu, en plus des sommes pouvant être attribuées en raison d'une poursuite (dans la mesure prévue par la loi).
- Si le travailleur choisit de demander des indemnités de la CAT plutôt que d'intenter une action en justice et de demander les indemnités prévues par la Loi sur les assurances, la CAT a le droit de poursuivre la tierce personne pour douleurs et souffrances.
- Si le travailleur choisit de demander les indemnités prévues par la Loi sur les assurances, puis découvre par la suite qu'il n'a pas droit à ces indemnités, il peut réclamer des indemnités de la CAT.

- Si le travailleur reçoit des indemnités de la CAT, puis par la suite, les indemnités prévues par la Loi sur les assurances, il n'a plus droit à des indemnités de la CAT. Cependant, il n'a pas à rembourser les indemnités de la CAT qu'il a reçues avant l'octroi des indemnités prévues par la Loi sur les assurances.
- Si le travailleur choisit de demander des indemnités de la CAT, il doit confirmer son choix (signer un autre avis d'option) avant de recevoir une indemnité pour PNE ou PEF de la CAT. Le travailleur ne peut modifier son choix après l'avoir confirmé.
- Si le travailleur décède, le conjoint ou les enfants à charge du travailleur doivent également confirmer leur choix de recevoir des indemnités de la CAT avant que la CAT ne puisse leur verser des paiements forfaitaires, aux termes de l'article 35 de la LAT. De même, le

- conjoint ou les enfants à charge ne peuvent modifier leur choix après l'avoir confirmé.
- Les membres du personnel de la Commission qui reçoivent des demandes d'indemnisation ayant trait à des accidents de véhicule automobile transmettent immédiatement de telles demandes à la Direction des services juridiques afin que les avis d'option puissent être envoyés. Des politiques qui énoncent ces modifications législatives et orientent les décideurs de la CAT sont actuellement en cours d'élaboration.
- \* Loi de 1993 modifiant les lois concernant les assurances
- \*\* Les règles diffèrent légèrement pour les employeurs de l'annexe 2.

## Message aux abonnés

Le *Bulletin des politiques* est de plus en plus en demande : notre liste d'abonnés, qui comptait 3 000 noms en 1988, en compte aujourd'hui 12 000. Nous nous réjouissons que cette publication connaisse un tel succès. Plusieurs d'entre vous qui représentez des travailleurs ou des employeurs l'avez utilisée dans vos programmes de formation et lors de séances d'information. Nous espérons que vous continuerez à le faire puisque le fait d'avoir les renseignements exacts aide à améliorer la prestation des services et à économiser de l'argent, même si ces aspects sont difficilement quantifiables.

Malgré la simplicité de notre publication, nous sommes toujours soumis à des contraintes budgétaires; c'est pourquoi nous ne pourrions plus nous permettre de vous fournir gratuitement des exemplaires **supplémentaires** du *Bulletin des politiques*.

Mais il y a un bon côté, malgré tout. Vous pouvez reproduire tout article ou même un numéro complet du *Bulletin des politiques*, à condition de mentionner la source et de ne pas vendre les reproductions, ni de les utiliser à des fins lucratives. De plus, si vous désirez avoir des exemplaires supplémentaires des numéros plus importants - ceux qui ont des encarts difficiles à photocopier - pour vos programmes de formation, nous verrons à ce que de tels exemplaires soient imprimés. Vous devrez simplement payer les coûts d'impression (voir ci-dessous) et placer votre commande au moins trois semaines avant la date requise.

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L'équipe de Publication des politiques vous souhaite une année remplie de santé et de prospérité.

Jean d'Ageais

Directrice de la rédaction, *Bulletin des politiques*

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Numéros avec encart [Processus d'indemnisation (Vol. 5, N° 6); Réadaptation professionnelle (Vol. 4, N° 4)] 2,00 \$ l'unité (plus TPS)

# Annexes 3 et 4

Si un travailleur contracte une maladie reliée au travail, ce travailleur ou les personnes à sa charge ont droit à des indemnités en vertu de la *Loi sur les accidents du travail*. Pour aider les décideurs à étudier les demandes d'indemnisation relatives à certaines maladies professionnelles, l'Assemblée législative de l'Ontario a constitué les annexes 3 et 4.

Chaque annexe comprend deux colonnes. La première colonne énumère ou décrit la maladie et la deuxième énumère le genre de travail effectué (procédé). L'ajout d'autres entrées à ces annexes nécessite l'amendement du *Règlement 1102* de la *Loi* par un comité législatif, et tout ajout doit être soumis à l'approbation du lieutenant-gouverneur en conseil.

L'annexe 3 du *Règlement 1102* des Règlements refondus de l'Ontario, 1990, a été modifiée le 16 décembre 1993 par l'ajout des éléments suivants :

Colonne 1	Colonne 2
Maladie	Travail effectué
16. Cancer primitif des fosses nasales ou des sinus de la face	Concentration, fusion ou raffinage dans l'industrie de la production du nickel

Aux termes de l'annexe 3, si l'on diagnostique chez un travailleur la maladie figurant à la colonne 1 et que celui-ci a effectué le travail énuméré à la colonne 2, il est préssumé que la maladie est attribuable à la nature de l'emploi, "jusqu'à preuve du contraire".

Aux termes de l'annexe 4, la même présomption relative au lien de causalité avec le travail s'applique aux travailleurs qui satisfont aux critères énoncés dans les colonnes 1 et 2; toutefois la clause "jusqu'à preuve du contraire" est exclue de l'annexe 4. Ainsi, si un travailleur satisfait aux critères énoncés dans les colonnes 1 (Maladie) et 2 (Travail effectué), la maladie est automatiquement considérée comme étant reliée au travail, et la demande d'indemnisation est acceptée. (En jargon juridique, on dit qu'il y a présomption irréfutuable que la maladie est attribuable à la nature de l'emploi.)

L'annexe 4 du règlement a été modifiée le 16 décembre 1993 par l'ajout des éléments suivants :

Colonne 1	Colonne 2
Maladie	Travail effectué
3. Cancer primitif des fosses nasales ou des sinus de la face	Tout procédé en application à l'usine de frittage d'INCO limitée à Copper Cliff.
4. Cancer primitif des fosses nasales ou des sinus de la face	Tout procédé en application au département de lixiviation, de calcination ou de frittage d'INCO limitée à Port Colborne tel qu'il a été utilisé avant 1966

L'annexe 3 compte maintenant seize entrées et l'annexe 4, quatre. Pour plus de précisions au sujet des récentes modifications (figurant dans les exemples donnés ci-dessus), voir l'article connexe à la page 2.

## Gains moyens...

suite de la page 1

- utilisant les gains moyens des travailleurs qui étaient employés par l'employeur ou par d'autres employeurs locaux et qui effectuaient un travail qui se rapproche le plus possible de celui qu'effectuait le stagiaire lorsqu'il a été blessé, si aucun travailleur n'était employé dans le métier localement.
- En pareil cas, la Commission tient compte également de la scolarité, des aptitudes et des compétences que le stagiaire aurait vraisemblablement eues à la fin de la période de formation.

### Étudiants

La CAT détermine les gains moyens de l'étudiant en utilisant la plus élevée des sommes suivantes :

- le taux hebdomadaire de rémunération
- les gains moyens des travailleurs qui exercent un emploi que l'étudiant exercerait vraisemblablement à la première des dates suivantes :

- la date à laquelle l'étudiant n'est plus atteint de déficience;

- la date à laquelle l'étudiant serait

vraisemblablement devenu un travailleur permanent à plein temps,

s'il n'avait pas été blessé.

En pareil cas, la CAT détermine les gains moyens de l'étudiant en se basant sur le salaire moyen dans l'industrie pour l'année de la lésion, ainsi que sur le niveau de scolarité, les aptitudes et les compétences de l'étudiant au moment de la lésion.

Pour plus de détails, consultez le Manuel des politiques opérationnelles.

Le Bulletin des politiques est imprimé sur du papier recyclé, exempt d'acide, et ce sans frais supplémentaires.





# Politique sur le cancer du nez

Le cancer du nez est une maladie rare. Au cours des dix dernières années, on a diagnostiqué en moyenne chaque année 41 cas de cancer du nez chez les hommes en Ontario. La plupart des causes connues sont professionnelles, les exceptions étant reliées à l'usage du tabac à priser et à l'injection dans les fosses nasales d'un radio-isotope, à des fins diagnostiques.

La CAT avait approuvé une politique sur le cancer du poumon et le cancer des sinus (nez) en 1981. Cependant, en raison de nouvelles données scientifiques, la CAT a entrepris un réexamen de politique - comportant une consultation externe - portant à la fois sur le cancer du poumon et le cancer du nez dans l'industrie de la production du nickel. Le réexamen de la politique sur le cancer du poumon n'est pas encore terminée, mais la politique sur le cancer du nez est entrée en vigueur le 16 décembre 1993, soit à la date où les amendements au *Règlement 1102* de la *Loi sur les accidents du travail*, qui ajoutent le cancer du nez aux annexes, ont été déposés par le lieutenant-gouverneur en conseil.

**Politique**

Le cancer primitif des fosses nasales et des sinus de la face est considéré comme une maladie professionnelle caractéristique d'un procédé, d'un métier ou d'une profession de l'industrie de la production du nickel. Si l'on diagnostique un cancer primitif des fosses nasales ou des sinus de la face chez un travailleur qui travaillait dans l'industrie de la production du nickel à la date de son incapacité reliée à la maladie, ou avant cette date, l'admissibilité de ce travailleur à des indemnités est envisagée en vertu de l'annexe 3 ou de l'annexe 4 de la *Loi*, chaque cas étant considéré individuellement.

**Industrie de la production du nickel**

Des études scientifiques internationales ont permis de préciser, dans l'industrie de la production du nickel, des activités qui accroissent considérablement le risque de cancer primitif du nez ou des sinus chez

les travailleurs. Si l'on diagnostique l'un de ces cancers chez un travailleur qui a été exposé dans le cadre de son emploi :

- à tout procédé en application, à un moment ou à un autre, à l'usine de frittage d'INCO limitée à Copper Cliff, ou
- à tout procédé en application avant 1966 au département de lixiviation, de calcination et de frittage d'INCO limitée à Port Colborne

il est vraisemblable que la maladie est reliée au travail, et le travailleur a automatiquement droit à des indemnités. Si l'on diagnostique un cancer primitif du nez ou des sinus chez un travailleur qui a été exposé dans le cadre de son emploi à des procédés de concentration, de fusion ou de raffinage dans l'industrie de la production du nickel, la maladie est réputée attribuable à la nature de l'emploi, jusqu'à preuve du contraire. De plus, les directives de la politique disent que les procédés en application dans la cuve électrolytique de la raffinerie de Port Colborne sont considérés comme étant des procédés de raffinage.

Habituellement, la période de latence pour le cancer du nez ou des sinus est de 15 ans ou plus. Par "période de latence", il faut entendre la période écoulée entre la date où le travailleur a été employé la première fois dans le milieu de travail et la date laquelle la maladie est diagnostiquée. Si un travailleur satisfait aux critères énoncés dans les colonnes 1 et 2 de l'annexe 3 et que la période de latence est de 15 ans ou plus, aucune autre preuve n'est requise dans la plupart des cas. Si un travailleur satisfait aux critères énoncés dans les colonnes 1 et 2 de l'annexe 3 mais que la période de latence est de moins de 15 ans, il faut tenir compte d'autres facteurs avant de déterminer que le contraire a été prouvé (voir l'article connexe à la page 3).

Lors de toute demande d'indemnisation relative au cancer primitif du nez ou des sinus, il faut tenir compte de l'ensemble des antécédents de travail du travailleur, étant donné que les travailleurs du nickel sont souvent exposés à plus d'un procédé

et peuvent, par conséquent, avoir été soumis à plus d'un genre d'exposition. Même les travailleurs affectés à l'exploitation minière ou au transport, ou encore au travail de bureau, d'entreposage, d'entretien ou de nettoyage peuvent avoir été exposés de façon significative dans d'autres lieux de travail reliés à l'industrie de la production du nickel.

**Autres industries**

Presque toutes les causes du cancer du nez ou des sinus sont professionnelles. Par conséquent, s'il est déterminé que le cancer du nez ou des sinus n'est pas attribuable à la nature du travail de concentration, de fusion ou de raffinage dans l'industrie de la production du nickel, la maladie peut toujours être attribuable à des causes professionnelles.

Voici d'autres causes reconnues de cette maladie qui sont de nature professionnelle :

- travail du bois (surtout chez les machinistes, charpentiers, menuisiers, scieurs, conducteurs de tour à bois et conducteurs de toupe) dans l'industrie de la fabrication des meubles et de l'ébénisterie;
- fabrication et réparation de chaussures et de bottes;
- fabrication d'alcool isopropylique;
- production de gaz moutarde;
- peinture fluorescente à base de radium.

À mesure que de nouvelles données scientifiques apparaissent, d'autres industries ou d'autres procédés de travail pourraient être reconnus comme des procédés ou des industries présentant un risque accru de cancer du nez. Chaque demande d'indemnisation qui se rapporte au cancer du nez est étudiée selon le bien-fondé du cas. Pour plus de détails, consultez le document 04-04-01 qui figurera dans la prochaine mise à jour du Manuel des politiques opérationnelles.

I Selon la Fondation ontarienne pour la recherche en cancérologie et le traitement du cancer.



## Gains moyens des apprentis, stagiaires et étudiants

L'article 14 du Règlement 1102 explique comment la CAT calcule les gains moyens des travailleurs qui sont apprentis, stagiaires ou étudiants. À la suite d'une consultation externe et d'un examen de politique, le règlement a été modifié en ce concerne les **stagiaires** qui ont subi une lésion le 16 décembre 1993 ou après cette date.

**Avant** que les modifications n'aient été apportées, la CAT utilisait le salaire de départ de l'emploi visé par la formation du stagiaire pour calculer les indemnités d'invalidité temporaire. Cependant, la majorité des personnes consultées estimaient que la perte de revenu subie par de nombreux stagiaires était inférieure au salaire de départ. Le règlement a donc été modifié pour qu'il soit mieux tenu compte des vraies pertes de revenu subies par les stagiaires.

Le texte qui suit **résume** comment la CAT calcule les gains moyens des apprentis, stagiaires et étudiants.

### **Apprentis**

La CAT détermine les gains moyens de l'apprenti en utilisant les gains moyens du travailleur qui a terminé son apprentissage (ouvrier, qui était employé par le même employeur et qui effectuait un travail identique à celui qu'effectuait l'apprenti lorsqu'il a été blessé.

Si un employeur n'employait aucun ouvrier qui effectuait un travail identique à celui qu'effectuait l'apprenti lorsqu'il a été blessé, la CAT détermine les gains moyens en utilisant le salaire moyen d'un ouvrier dont l'emploi était identique à celui qu'effectuait l'apprenti au moment de l'accident dans la localité de l'employeur.

### **Stagiaires**

Lors du calcul des **indemnités d'invalidité temporaire**, la CAT détermine maintenant les gains moyens du travailleur qui est stagiaire en :

- utilisant le revenu total qu'il avait reçu au moment de la lésion, ce revenu prenant fin au moment où le versement des indemnités de la CAT débute. Le revenu comprend les allocations de formation, les prestations d'aide sociale, les indemnités d'assurance et les prestations d'assurance-chômage; utilisant le salaire minimum en Ontario au moment de la lésion, si le stagiaire n'avait pas de revenu lorsqu'il a été blessé;

- appliquant la politique 05-02-05 de la CAT portant sur les emplois simultanés lorsque le stagiaire touche un salaire, au moment de la lésion, pour un travail qu'il effectuait en même temps que la formation, si le stagiaire n'a pas accepté une offre d'emploi; utilisant le salaire de départ d'un emploi que le stagiaire a accepté et qui doit débiter à la fin de la période de formation.

### **Lors du calcul de la perte de gains future**, la CAT détermine les gains

- utilisant les gains moyens du travailleur qui était employé par le même employeur et qui effectuait un travail identique à celui qu'effectuait le stagiaire lorsqu'il a été blessé; utilisant le salaire moyen d'un travailleur dont l'emploi est identique à celui qu'occupait le stagiaire au moment de l'accident dans la localité de l'employeur, si l'employeur n'employait aucun travailleur qui effectuait un travail identique à celui qu'effectuait le stagiaire lorsqu'il a été

blessé;

*suite à la page 3*

## L'assurance auto et les indemnités de la CAT

Dans le présent article, nous traitons du travailleur uniquement. Cependant, dans le cas d'un travailleur décédé, le conjoint ou les personnes à charge du travailleur peuvent également demander des indemnités\* ou de la Loi sur les accidents du travail (LAT).

Le projet de loi 164, entré en vigueur le 1<sup>er</sup> janvier 1994, apporte des modifications à diverses lois, dont la LAT et la Loi sur les assurances; cette dernière loi a établi le régime d'assurance automobile sans

égard à la responsabilité. La LAT prévoit que les travailleurs qui sont victimes d'un accident de véhicule automobile relié au travail et qui ont le droit d'intenter des poursuites contre une personne (tiers personne) autre que l'employeur ou un autre travailleur peuvent soit demander des indemnités de la CAT, soit intenter une action contre la tiers personne\*. Cette disposition du paragraphe 10 (1) de la LAT demeure

inchangée. Désormais, en vertu du projet de loi 164, les travailleurs peuvent choisir de réclamer les indemnités prévues par :

- 1) la Loi sur les assurances : dans ce cas, ils peuvent également intenter une action en justice contre la tiers personne pour les pertes non pécuniaires (douleurs et souffrances)
- 2) la LAT.

choix effectué.

Ce choix s'appelle option, et le travailleur signe un avis d'option pour indiquer le

*suite à la page 4*



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# POLICY REPORT



Workers'  
Compensation  
Board

Commission  
des accidents  
du travail

April 1994  
Vol. 7 No. 2

## Medical reports - Forms 8 and 26



Medical information is crucial to the decision-making process. If a worker has a work-related injury/disease, the employer and the treating physician take immediate steps to report the injury to the WCB.

- Employers notify the WCB within 3 calendar days of learning of an injury/disease, using the Employer's Report of Injury/Disease—Form 7, or a WCB-approved facsimile of the form (OP manual document 02-02-03).
- The physician/hospital emergency medical staff who first treats the injured worker completes and returns the Physician's First Report—Form 8 to the WCB (OP manual document 02-02-04).
- If the injury is prolonged, the WCB sends the worker the Physician's Progress Report—Form 26. The worker takes the form to the treating physician who completes and returns it to the WCB (OP manual document 02-02-05).
- Once a claim is registered, the WCB sends the worker the Worker's Report of Injury/Disease—Form 6. Here, the worker can describe the work-related injury/disease and provide other pertinent information (OP manual document 02-02-02).

In addition, there are a number of medical reporting forms that other health-care practitioners complete for the WCB, among

them the Dental Report—Form 8B, and the Chiropractor's First Report—Form 8C.

WCB decision-makers rely heavily on external treating physicians to

- describe the worker's injury/disease

### S. 51 of the *Workers' Compensation Act* states:

Every physician, surgeon, hospital official or other person attending, consulted respecting, or having the care of, any worker shall furnish to the Board from time to time such reports as may be required by the Board in respect of such worker.

### The *Act* (s.115) further states:

Every report made under s. 51 and every other report made or submitted to the Board by a physician, surgeon, hospital, nurse, dentist, drugless practitioner, chiroprapist or optometrist is for the use and purposes of the Board only, is deemed to be a privileged communication of the person making or submitting the same....

- diagnose the injury/disease
- propose treatment plans
- provide a prognosis—forecasting the course of an injury/disease and the possibility of recovery and return to work
- identify temporary or permanent medical restrictions.

At the request of decision-makers, WCB physicians evaluate medical information submitted by treating physicians for completeness and accuracy. If WCB physicians identify problems, they contact the treating physicians for more information or for clarification. It is also the role of WCB physicians to assist in weighing and interpreting the clinical information as it relates to maximum medical rehabilitation (see OP manual document 05-03-11), and whether there will be a residual permanent impairment.

If the worker is considered to be temporarily or permanently impaired, the vocational caseworker, the employer, and the worker, look at how the work or work-site might be

modified to accommodate the injured worker.

*Note: The December 1993 issue of Policy Report (Vol.6 No.7) deals exclusively with Forms 6 and 7.*

## Ordering the Form 8

In most cases, physicians who are registered with the WCB, and hospitals, have a supply of Form 8s in their offices and emergency rooms. Whenever supplies run out or get low, they place an order through the WCB's regional office or head office.

On occasion, a worker may not specify that the injury is work related, or the physician/hospital may not have a supply of forms on hand—making it impossible to file the report. When this occurs, adjudicators can generate a Form 8 (and a covering letter) from the Forms System (System 35), and send it either to the **worker** (Form M) or to the **physician** (Form J1). The letter and the form are sent to physicians only when adjudicators can identify from the claim file who the first treating physician was. Otherwise, adjudicators send the letter/form to the worker.

## Submitting a Form 8

Physicians/hospitals are urged to send medical reports to the WCB

within 2 working days following the medical assessment on which the report is based.

Physicians/hospitals may choose to mail, fax or, in some cases, give the report to the worker to take to the WCB. (For addresses, phone and FAX numbers, see OP manual document 99-01-02.)

- It is important for physicians to report if a worker is undergoing any treatment, and if or when significant improvement can be expected.
- Physicians are encouraged to name the medical restrictions, i.e., activities that should be avoided to prevent any harm to the injured worker.
- Physicians must indicate the duration of the restrictions and whether these restrictions are likely to be temporary or permanent.
- Physicians indicate drug treatment—dosage and anticipated duration.

## Physician's Progress Report—Form 26

Treating physicians provide on-going medical information to the WCB by completing and forwarding the Form 26. Claims adjudicators send the form to workers who take it to their physicians to complete and return to the WCB.

## Completing the forms

There are 13 itemized sections in each of the forms (see insert). The questions must be answered in as much detail as possible. If there is not enough space in a given section, physicians are asked to use an additional sheet of paper.

*Do not leave any sections of the forms blank. Write "N/A" if appropriate.. Leaving sections blank could result in telephone calls from WCB decision-makers, and further delay in processing the claim.*

### Has your address changed?

To ensure you receive each issue of *Policy Report*, and to keep our mailing costs down, we need to keep our distribution list up-to-date. Please submit any changes in your mailing address to:

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**Comments or inquiries should be addressed to:**

Editor  
**Policy Report**  
Policy Publications  
Workers' Compensation Board  
2 Bloor Street East, 22nd Floor  
Toronto, Ontario M4W 3C3



Dans la plupart des cas, les médecins et les hôpitaux inscrits auprès de la CAT ont des exemplaires du formulaire 8 dans leur bureau ou leur salle des urgences.

Pour commander de nouveaux formulaires, il leur suffit de s'adresser à un bureau régional ou au Bureau central de la CAT.

Il peut arriver parfois qu'un

travailleur ne dise pas qu'une lésion est reliée au travail ou que le

médecin ou le personnel hospitalier ne possède pas de formulaire, d'où

l'impossibilité de l'envoyer. En pareil cas, les agents peuvent

produire un formulaire 8 ainsi qu'une lettre d'accompagnement

informatisés (à partir du «Système 35») et l'envoyer soit au **travailleur**

(formulaire M) ou au **médecin**

(formulaire J1). La lettre et le formulaire sont envoyés aux

médecins dans les seuls cas où les agents peuvent déterminer, selon

les renseignements contenus dans le dossier, qui a été le premier

médecin traitant. Autrement, ils envoient le formulaire et la lettre au

travailleur.

## Envoi du formulaire 8

Les médecins ainsi que le personnel hospitalier sont priés d'envoyer les rapports médicaux à la CAT dans les deux jours

*Veillez remplir toutes les sections. Inscrivez au besoin la mention «S/O» (sans objet). Si vous omettez de remplir toutes les sections, il se pourrait que les décideurs de la CAT doivent vous appeler, ce qui pourrait occasionner un retard dans le traitement de la demande d'indemnisation.*

## Avez-vous changé d'adresse?

Afin de nous assurer que vous recevez chaque numéro du Bulletin des politiques et de garder nos frais de poste à la baisse, nous devons tenir notre liste d'envoi à jour. Veuillez donc communiquer tout changement d'adresse au :

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Téléphone : (416) 927-4941  
Télécopieur : (416) 927-3821

ouvrables qui suivent la date de l'évaluation médicale qui a donné lieu au rapport.

• Il est important que les médecins précisent tout traitement que suit un travailleur, et qu'ils indiquent si une amélioration significative est prévisible, et quand.

• Nous incitons les médecins à

préciser les restrictions médicales, c.-à-d. les activités auxquelles le

travailleur blessé doit éviter de se livrer, au risque de se blesser.

• Les médecins doivent également indiquer la période d'application des

restrictions et préciser si les restrictions seront vraisemblablement

temporaires ou permanentes.

• Les médecins indiquent le traitement médicamenteux, la posologie des

médicaments et la durée prévue du traitement.

## Rapport d'évolution (médecin) - Formulaire 26

politiques opérationnelles.)

politique 99-01-02 du Manuel des

téléphone et de télécopieur figure dans la

(La liste des adresses et des numéros de

qui les apportera directement à la CAT.

dans certains cas, être remis au travailleur

la poste ou par télécopieur, ou même

Les rapports peuvent être acheminés par

la poste ou par télécopieur, ou même

Les médecins traitants fournissent une

information continue à la CAT en

remplissant et en retournant le

formulaire 26. Les agents

d'indemnisation envoient le formulaire

aux travailleurs qui le remettent à leur

médecin. Les médecins, à leur tour,

remplissent le formulaire et le retournent

à la CAT.

Chaque formulaire comporte 13 sections

numérotées (voir encart), et chacune comprend des questions

auxquelles il faut répondre le plus complètement possible.

Lorsque l'espace est insuffisant pour la réponse à inscrire, les

médecins doivent utiliser une feuille séparée.

## BULLETIN DES POLITIQUES

Le **Bulletin des politiques** est publié par la Direction des politiques sur l'indemnisation de la Commission des accidents du travail. S'il y a contradiction entre le texte de la présente publication et la *Loi sur les accidents du travail* et/ou les politiques approuvées de la Commission, c'est à la Loi ou aux documents approuvés qu'il faut se référer.

Veillez adresser vos questions ou commentaires à la :

Rédactrice  
**Bulletin des politiques**  
Publication des politiques  
Commission des accidents du travail  
2, rue Bloor Est, 22<sup>e</sup> étage  
Toronto (Ontario) M4W 3C3



## Rapports médicaux - Formulaires 8 et 26

Les renseignements médicaux sont d'une importance capitale dans le processus décisionnel. Lorsqu'un travailleur subit une lésion ou contracte une maladie reliées au travail, l'employeur et le médecin traitant prennent des mesures immédiates afin de déclarer la lésion ou la maladie à la CAT.

L'employeur informe la CAT dans les trois jours civils qui suivent le moment où il apprend la survenue d'une lésion ou l'apparition d'une maladie, en utilisant l'Avis de lésion ou de maladie (employeur) - Formulaire 7 ou un fac-similé de ce formulaire, approuvé par la CAT (politique 02-02-03).

Le médecin ou le personnel du service des urgences de l'hôpital qui traite en premier le travailleur blessé remplit le Premier rapport du médecin - Formulaire 8 et le retourne à la CAT (politique 02-02-04).

Si la consolidation de la lésion est de longue durée, la CAT envoie au travailleur le Rapport d'évolution (médecin) - Formulaire 26. Le travailleur remet ce formulaire au médecin traitant qui le remplit et le retourne à la CAT (politique 02-02-05).

Lorsqu'une demande d'indemnisation est enregistrée, la CAT envoie au travailleur l'Avis de lésion ou de maladie (travailleur) - Formulaire 6. Ce formulaire permet au travailleur de décrire la lésion ou la maladie reliées au travail et de fournir d'autres renseignements utiles (politique 02-02-02). Il y a également d'autres formulaires que doivent remplir pour la CAT les professionnels de la santé, dont le Rapport du dentiste - Formulaire 8B et le Premier rapport du chiropraticien - Formulaire 8C.

L'article 51 de la Loi sur les accidents du travail dit :  
Le médecin, le chirurgien, le responsable d'un hôpital ou l'autre personne qui donne des soins à un travailleur, qui est consulté à son sujet ou qui est chargé de le soigner fournit à la Commission les rapports que celle-ci peut demander au sujet de ce travailleur.  
De plus, l'article 115 de la Loi dit :

Le rapport établi en vertu de l'article 51 et celui que transmet ou présente à la Commission un médecin, un chirurgien, un hôpital, une infirmière ou un infirmier, un dentiste, un praticien ne prescrivant pas de médicaments, un podologue ou un optométriste sont réservés à l'usage et aux fins de la Commission seulement et sont réputés une communication privilégiée de la part de leur auteur (...)

- établissent le diagnostic relatif à la lésion ou à la maladie;
- proposent des plans de traitement;
- fournissent un pronostic servant à prédire l'évolution d'une lésion ou d'une maladie, ainsi que la possibilité d'un rétablissement et d'un retour au travail;
- déterminent les restrictions médicales temporaires ou permanentes.

À la demande des décideurs, les médecins de la CAT évaluent les renseignements médicaux présentés par les médecins traitants pour s'assurer que l'information est complète et précise. Si les médecins de la CAT relèvent des difficultés, ils communiquent avec les médecins traitants pour obtenir plus de renseignements ou des précisions. Il appartient également aux médecins de la CAT d'aider à l'évaluation et à l'interprétation de l'information clinique relative à la réadaptation médicale maximum (politique 05-03-11) et de déterminer s'il y aura une déficience permanente résiduelle.

Si le travailleur est jugé atteint de déficience temporaire ou permanente, l'agent de réadaptation professionnelle, l'employeur et le travailleur considèrent comment il serait possible de modifier le travail ou le lieu de travail en vue de répondre aux besoins du travailleur blessé.

- Les décideurs de la CAT se fient, dans une grande mesure, aux médecins traitants pour qu'ils :
- fournissent une description de la lésion ou de la maladie du travailleur;



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Government  
Publication

# Policy Report



Workers'  
Compensation  
Board

Commission  
des accidents  
du travail

May 1994  
Vol. 7 No. 3

## Occupational Disease

Approximately 5 per cent of the 370,000 WCB claims registered in Ontario in 1993 were for occupational diseases. While this seems like a small number, these claims are among the most difficult and time-consuming to adjudicate. This issue of *Policy Report* defines occupational disease, explains why disease claims are difficult to adjudicate, and gives a history of occupational disease in the Ontario workers' compensation system.

### What is an occupational disease?

Scientists in the field of occupational health consider a disease to be occupational when an individual's work causes the disease. The International Labour Organization (ILO) defines occupational diseases as all pathological conditions—conditions caused by a physical disorder—induced by prolonged work. Established in 1919, the ILO is a specialized agency of the United Nations, comprised of government, employer, and worker representatives from 146 countries.

The *Workers' Compensation Act* (the *Act*) does not use the term "occupational disease." It does, however, use the term **industrial disease** and defines it in s.1(1) as follows:

- (a) a disease resulting from exposure to a substance relating to a particular process, a trade or occupation in an industry,
- (b) a disease peculiar to or characteristic of a particular industrial process, trade or occupation,
- (c) a medical condition that in the opinion of the Board requires a worker to be removed either temporarily or permanently from exposure to a substance because the condition may be a precursor to an industrial disease, or

- (d) any of the diseases mentioned in Schedule 3 or 4.

Unlike the ILO, the *Act* recognizes not only diseases caused by prolonged work, but also recognizes diseases that are caused by acute work-related exposures.

### How do scientists describe diseases?

One way the scientific community describes diseases is by the length of time it takes for a disease to appear (the latency) following exposure to the agent that causes the disease. The onset of some diseases is immediate, or **acute**. Other diseases take a long time after exposure to the causal agent to produce physical symptoms. They are considered to have a **delayed** onset.

### Acute onset diseases

Causes of diseases that have an acute onset are the easiest to recognize. For scientists, medical practitioners who do the "detective" work, and WCB decision-makers who have to determine whether a disease is work-related, the clues are there—place, time, activity, plus exposure to the agent, and acute onset of the physical symptoms. Some of the industrial diseases listed in Schedule 3 fall into the acute onset category—compressed air illness, poisoning, or ulceration of the corneal surface of the eye, for example.

### Delayed onset diseases

It is far more difficult to identify causation in diseases that have a delayed onset. Unlike acute onset conditions, delayed onset diseases are not immediately apparent after the exposure, and the evidence required to show their cause and effect may be hidden or complicated by other factors. For instance, there may be both work and non-work factors that contribute to the development of the disease. And although scientists may be able to identify the occupational groups at high risk of developing a particular disease, medical experts cannot be absolutely sure whether the workplace has been an important contributor to the individual worker's disease. For example, lung cancer in a gold miner looks the same whether it is caused by occupational agents or by smoking.

Delayed onset diseases consist of both **long latency** diseases and diseases caused by **cumulative exposure**.

#### • Long latency

The onset of a disease could be delayed because the disease has a long latency. Long latency means there is a long period of time between the exposure responsible for causing the disease and the manifestation or outward signs of the disease. Cancer is an example of a long latency disease.

### • Cumulative exposure

The onset of a disease could also be delayed due to cumulative exposure to the causal agent. Cumulative exposure diseases develop when harmful effects of repeated exposure accumulate to produce the disease or condition. Examples are hand-arm vibration syndrome from exposure to vibration, and carpal tunnel syndrome from repetitive motion.

### Causation

To determine whether a disease is **caused** by a particular exposure, scientists evaluate evidence produced from several studies. To assist their evaluation, scientists often use the Bradford Hill criteria<sup>1</sup>, which include:

- **strength of the association**  
the degree of risk of developing a disease from a specific occupation or exposure
- **consistency of the association**  
when several studies show similar results
- **temporality**  
in terms of timing, whether studies show the exposure occurred prior to the disease
- **biological gradient**  
whether increased exposure to an agent causing a disease also increases the risk of developing a disease
- **biological plausibility**  
credibility according to what is known within the principles of biology

Not all of these scientific criteria must be met to establish causation. However, the more that **are** met, the likelier it is that scientists can establish a causal relationship between the occupation and the disease.

1. Bradford Hill, A.. The environment and diseases: Association or Causation. Proceedings of the Royal Society of Medicine 1965, 58: 295-300.

Column 1 Description of Disease	Column 2 Process
1. Anthrax	Handling of wool, hair, bristles, hides and skins
2. Infected blisters	Any process involving continuous friction
3. Bursitis	
4. Epitheliomatous cancer or ulceration of the skin due to tar, pitch, bitumen, mineral oil or paraffin or any compound, product or residue of any of these substances	Handling or use of tar, pitch, bitumen, mineral oil or paraffin or any compound, product or residue of any of these substances
5. Compressed-air illness or caisson disease	Any process carried on in compressed air
6. Dermatitis venenata	
7. Poisoning and its sequelae by	
i. arsenic	Any process involving the use of arsenic or its preparations or compounds
ii. benzol	Any process involving the use of benzol
iii. beryllium	Any process involving the use of beryllium or its preparations or compounds
iv. brass, nickel or zinc	Any process involving the use of brass or nickel or melting or smelting zinc
v. cadmium	Any process involving the use of cadmium or its preparations or compounds
vi. carbon bisulphide	Any process involving the use of carbon bisulphide or its preparations or compounds
vii. carbon dioxide	Any process involving the evolution of carbon dioxide
viii. carbon monoxide	Any process involving the evolution of carbon monoxide
ix. chlorinated hydrocarbons (carbon tetrachloride, trichlorethylene, tetrachlorethane, trichloronaphthalene and others)	Any process in the manufacture or involving the use of these substances
x. chrome	Any process involving the use of chromium or its compounds
xi. lead	Any process involving the use of lead or its preparations or compounds
xii. mercury	Any process involving the use of mercury or its preparations or compounds



## Schedule 3

Column 1 Description of disease	Column 2 Process
xiii. nitro derivatives and amino derivatives of benzene, phenol and their homologues (trinitrotoluene, dinitrophenol, anilin and others)	Handling any nitro derivatives or amino derivatives of benzene or phenol or any of their homologues or any process in the manufacture or use thereof
xiv. nitrous fumes	Any process in which nitrous fumes are evolved
xv. phosphorus	Any process involving the use of phosphorus or its preparations or compounds
8. The pneumoconioses other than silicosis	
9. Any disease due to exposure to X-rays, radium or other radioactive substances	
10. Respiratory disease due to the inhalation of materials used in non-offset sprays	Any process or occupation involving the use of non-offset sprays in the printing industry
11. Retinitis due to electro-welding or acetylene-welding	
12. Silicosis	Mining or quarrying, cutting, crushing, grinding or polishing stone, or grinding or polishing metal
13. Teno-synovitis	
14. Tuberculosis contracted by an employee employed by and in, <ul style="list-style-type: none"> <li>i. a hospital, jail, sanatorium, convalescent home, nursing home, home for the aged, health unit or visiting nursing association to which Part I of the Act applies; or</li> <li>ii. a laboratory, reform institution, health unit or treatment centre operated by the Province of Ontario</li> </ul>	
15. Ulceration of the corneal surface of the eye, due to tar, pitch, bitumen, mineral oil or paraffin, or any compound, product or residue of any of these substances	Handling or use of tar, pitch, bitumen, mineral oil or paraffin, or any compound, product or residue of any of these substances
16. Primary cancer of the nasal cavities or of paranasal sinuses	Concentrating, smelting or refining in the nickel producing industry

### "True" and multi-causal occupational diseases

Some scientists place occupational diseases in two categories:<sup>2</sup> "true" and multi-causal. They define "true" occupational diseases as those whose cause is found primarily in the workplace. Asbestosis, a lung disease caused by inhaling large amounts of asbestos particles, is considered to be a "true" occupational disease because if an individual has the disease, it could only have been caused by working with asbestos in the workplace. Multi-causal diseases are those that have more than one cause. More detailed information about the industry and occupation of the worker is required before an individual's disease can be considered occupational.

### Evolution of the Act with respect to diseases

As the medical and scientific communities have become more knowledgeable about diseases, the Act has evolved to recognize more and more diseases as industrial in nature.

Sir William Meredith, founder of the Ontario workers' compensation system, stated in 1913:

"...industrial diseases are put on the same footing as to the right of compensation as accidents....It would, in my opinion, be a blot on the Act if a workman who suffers from an industrial disease contracted in the course of his employment is not to be entitled to compensation. The risk of contracting disease is inherent in the occupation he follows and he is practically powerless to guard against it."

2. Mullan, R.J., and Murphy, L.I., Occupational sentinel health events: An up-dated list for physician recognition and public health surveillance. American Journal of Industrial Medicine, 1991, p. 775-799.

# Evolution of the Act...

continued from page 3

When the *Act* came into effect in 1915, there was little difficulty in determining that the diseases listed in Schedule 3 were work-related (Schedule 4 did not exist). For example:

- anthrax—an infectious disease caused from handling wool, hair, bristles, hides, and skins
- ankylostomiasis—a hookworm disease commonly found among miners
- lead poisoning and its after effects, and poisoning from other metals and substances (arsenic, mercury, phosphorous).

In 1926, silicosis and pneumoconiosis—lung diseases caused by inhaling silica, coal, asbestos, and talc dust—were added to Schedule 3 and the WCB accepted the first silicosis and asbestosis claims that year.

Until 1947, only the diseases listed in Schedule 3 could be considered industrial. In that year, the *Act* was expanded to recognize industrial diseases as “any other disease peculiar to or characteristic of a particular process, trade, or occupation.” As a result, the WCB began developing policies and guidelines to determine entitlement for new industrial diseases, such as noise-induced hearing loss (NIHL). NIHL is a permanent loss of hearing in both ears resulting from sensorineural (inner ear) damage due to prolonged, continuous, hazardous noise exposure.

In 1963, the legislature recognized that cumulative exposure to workplace factors can cause diseases, and added a disablement provision to the *Act*.

Under s.1(1), an accident includes “disablement arising out of and in the course of employment.” Operational Policy (OP) manual document 03-01-01 defines a “disablement” as

- a condition that emerges gradually over time
- an unexpected result of working duties.

The 1970s and '80s saw a heightened awareness of occupational diseases.

These epidemiological reviews identified a number of occupational diseases present among miners, including lung cancer, silicosis, and diseases from radiation exposure.

In 1984, The Royal Commission on Matters of Health and Safety Arising from the Use of Asbestos in Ontario identified asbestosis, mesothelioma (cancer on the surface of the lung and abdominal cavities), lung cancer, gastrointestinal cancer, and laryngeal cancer as occupational diseases attributable to asbestos exposure. As a result, the WCB recognized these diseases as

industrial diseases and developed policies and made recommendations for changes to the *Act* (see documents 04-04-05, 04-04-15, 04-04-16, 04-04-14, and 04-04-13 in the OP manual).

During the same period, Paul Weiler, a Harvard University legal expert on workers' compensation, wrote a series of reports about workers' compensation in Ontario. He recommended changes to the definition of industrial

disease, and recommended the creation of the Industrial Disease Standards Panel (IDSP). The IDSP makes recommendations to the WCB concerning the recognition of new industrial diseases and criteria for entitlement. Their most recent recommendation resulting in a new industrial disease policy was for scleroderma, OP manual document 04-04-22.

Brief biographical notes on IDSP panel members are on page 5. See also *Policy Report*, Vol. 6 No. 4.

## Schedule 4

Column 1 Description of Disease	Column 2 Process
1. Asbestosis	Any mining, milling, manufacturing, assembling, construction, repair, alteration, maintenance or demolition process involving the generation of airborne asbestos fibres.
2. Primary malignant neoplasm of the mesothelium of the pleura of peritoneum	Any mining, milling, manufacturing, assembling, construction, repair, alteration, maintenance or demolition process involving the generation of airborne asbestos fibres.
3. Primary cancer of the nasal cavities or of paranasal sinuses.	Any process at the Copper Cliff sinter plant of Inco Limited.
4. Primary cancer of the nasal cavities or of paranasal sinuses	Any process in the Port Colborne leaching, calcining and sintering department of Inco Limited that was practised before January 1, 1966.

For example, the Ham Commission recommended that an epidemiological review of the mining workforce be carried out every 5 years. The science of occupational epidemiology

- identifies and assesses causes of disease
- measures disease occurrence rates
- determines exposure limits
- identifies how disease can be prevented or controlled.<sup>3</sup>

3. Preventing Occupational Disease and Injury, James L. Weeks, Barry S. Levy, and Gregory R. Wagner, eds., American Public Health Association, 1991, p. 36.



# Consultation invited

The Industrial Disease Standards Panel (IDSP) has recently submitted a report to the WCB entitled "Report to the Workers' Compensation Board on Lung Cancer in the Hardrock Mining Industry."

The report was published in *The Ontario Gazette* on May 7, 1994, and the deadline for submissions on this report is September 5, 1994.

Reports are available from:

Industrial Disease Standards Panel  
69 Yonge Street, Suite 1004  
Toronto, Ontario M5E 1K3  
Tel: (416) 327-4156

If you would like to provide the WCB with comments, briefs, or submissions, send them to:

Ms. Linda Angove  
Secretary to the Board  
Workers' Compensation Board  
2 Bloor Street East  
Toronto, Ontario M4W 3C3



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**Policy Report**  
Policy Publications  
Workers' Compensation Board  
2 Bloor Street East, 22nd Floor  
Toronto, Ontario M4W 3C3

## IDSP Who's Who

The Industrial Disease Standards Panel (IDSP) operates independently of the WCB and the Ministry of Labour and is made up of 9 members. They are:

### Nicolette Carlan Chair

Ms. Carlan was a vice-chair with the Workers' Compensation Appeals Tribunal (WCAT) for 5 years. Before that she was assistant director of the Office of the Ontario Ombudsman for 10 years and supervised investigations concerning WCB and social benefits.

### Jim Brophy Community Representative

Mr. Brophy is executive director of the Windsor Occupational Health Information Service and chair of the Windsor Occupational Safety and Health Council Board. He has promoted health in the workplace for over 10 years.

### Carol Buck Scientist

Dr. Buck is professor emerita in the Department of Epidemiology and Biostatistics at the University of Western Ontario, and a member of the Advisory Committee on Health Statistics for Statistics Canada. She is former president of the International Epidemiological Association, has served on provincial, national, and international health committees, and has written many articles on epidemiology.

### Robert DeMatteo Labour Representative

Mr. DeMatteo has been the coordinator of Occupational Health and Safety with the Ontario Public Service Employees Union (OPSEU) since 1977. He has extensive knowledge of occupational health issues and epidemiology.

### Nicole Godbout Community Representative

Ms. Godbout is a lawyer (bilingual) employed by the Industrial Accident

Victims Group of Ontario—a legal aid clinic representing workers at the WCB and WCAT.

### Bill Elliott Management Representative

Mr. Elliott is a professional engineer employed at Inco and has been secretary of a company/union bi-partite Joint Occupational Health Committee for over 8 years. He is an expert in engineering, workplace hygiene, mining, and refining.

### Homer Seguin Labour Representative

Mr. Seguin is a member of the WCB's Board of Directors and a former coordinator for the United Steelworkers of America. He has over 30 years of experience in safety, environment, and health issues, including lung cancer amongst gold, mixed ore, uranium, and nickel miners.

### John Macnamara Management Representative

Mr. Macnamara works in employee and corporate relations for Dofasco and has represented the Ontario Chamber of Commerce on the Government Task Force for the Provincial Environmental Bill of Rights.

### Michael Wills Occupational Physician

Dr. Wills is a physician accredited in occupational medicine and is an occupational medicine consultant at the Danforth Occupational Health Clinic for Ontario Workers. He is also an assistant professor in the University of Toronto's Faculty of Medicine and secretary-treasurer of the Canadian Board of Occupational Medicine. He is the former chief physician and manager of Ontario Hydro's Health Services Department.

# Consultation

Le Comité des normes en matière de maladies professionnelles (CNMMP) a récemment présenté à la Commission un rapport intitulé «Report to the Workers' Compensation Board on Lung Cancer in the Hardrock Mining Industry».

Ce rapport a été publié dans la *Gazette de l'Ontario* le 7 mai 1994. La date limite pour présenter des mémoires a été fixée au 5 septembre 1994.

Vous pouvez obtenir une copie du rapport susmentionné auprès du :

Comité des normes en matière de maladies professionnelles

69, rue Yonge, bureau 1004

Toronto (Ontario) M5E 1K3

Téléphone : (416) 327-4156

Veillez présenter vos observations ou mémoires à :

Mme Linda Angove

Secrétaire du conseil

Commission des accidents du travail

2, rue Bloor Est

Toronto (Ontario) M4W 3C3



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entre le texte de la présente publication et

la Loi sur les accidents du travail et/ou les

politiques approuvées de la Commission,

c'est à la Loi ou aux documents approuvés

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Rédactrice

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2, rue Bloor Est, 22<sup>e</sup> étage

Toronto (Ontario) M4W 3C3

# Les membres du CNMMP

Le Comité des normes en matière de maladies professionnelles (CNMMP) est un organisme qui fonctionne de façon indépendante par rapport à la CAT et au ministère du Travail. Le CNMMP est composé de neuf membres :

**Nicolas Carlan**

Présidente

Mme Carlan a occupé un poste de vice-présidente au Tribunal d'appel des accidents

du travail (TAAT) pendant cinq ans.

Auparavant, elle a été directrice adjointe du

Bureau de l'Ombudsman de l'Ontario

pendant 10 ans; elle supervisait alors les

enquêtes touchant les indemnités de la CAT

et les prestations sociales.

**Jim Brophy**

Représentant du public

M. Brophy est directeur du Windsor

Occupational Health Information Service et

président du Windsor Occupational Safety

and Health Council Board. Il fait la

promotion de la santé au travail depuis plus

de dix ans.

**Carol Buck**

Scientifique

Le docteur Buck est professeur émérite au

département d'épidémiologie et de biométrie

de l'Université Western Ontario et est

membre du Comité consultatif de la

statistique de la santé de Statistique Canada.

Elle a été présidente de l'Association

internationale d'épidémiologie et membre de

comités provinciaux, nationaux et

internationaux sur la santé. De plus, elle a

révisé plusieurs articles portant sur

l'épidémiologie.

**Robert DeMatteo**

Représentant des travailleurs

M. DeMatteo est coordonnateur de la santé

et de la sécurité au travail au sein du

Syndicat des employés de la Fonction

publique de l'Ontario (SEFPO) depuis 1977.

Il a des connaissances approfondies dans les

domaines de la santé au travail et de

l'épidémiologie.

**Nicole Godbout**

Représentante du public

Mme Godbout est une avocate bilingue qui

travaille pour le Industrial Accident Victims

Group of Ontario, une clinique d'aide

juridique qui représente les travailleurs

auprès de la CAT et du TAAT.

**Bill Elliott**

Représentant des employeurs

M. Elliott est ingénieur pour la compagnie

INCO et secrétaire d'un comité mixte sur la

santé au travail depuis plus de huit ans. Il

est un expert dans les domaines du génie, de

l'hygiène du travail, de l'exploitation

minière et du raffinage.

**Homer Séguin**

Représentant des travailleurs

M. Séguin est membre du conseil

d'administration de la CAT et a été

coordonnateur pour le syndicat des

Métallurgistes unis d'Amérique. Il a plus

de trente ans d'expérience en ce qui a trait

aux questions touchant la sécurité,

l'environnement et la santé, y compris le

cancer du poumon chez les travailleurs des

mines d'or, de minerais complexes,

d'uranium et de nickel.

**John Macnamara**

Représentant des employeurs

M. Macnamara travaille chez Dofasco, où il

s'occupe des relations employeur-employé.

Il a représenté la Chambre de commerce de

l'Ontario (Ontario Chamber of Commerce)

au sein du Groupe d'étude gouvernemental

sur la Charte des droits environnementaux

de l'Ontario.

**Michael Willis**

Médecin du travail

Le docteur Willis est spécialisé en médecine

du travail et il est consultant dans ce

domaine pour le Centre de santé des

travailleurs de l'Ontario (Toronto) inc. Il

est également professeur adjoint à la Faculté

de médecine de l'Université de Toronto et

secrétaire-trésorier de la Commission

canadienne de la médecine du travail. De

plus, il a occupé les fonctions de médecin

en chef et directeur des Services de santé

chez Ontario Hydro.



qu'une maladie figurant à l'annexe 3 était reliée au travail (l'annexe 4 n'existait alors pas). C'était le cas pour :

- l'anthrax : une maladie infectieuse résultant de la manipulation de la laine, du crin, du poil, du cuir et des peaux.
- l'ankylostomiase : maladie parasitaire souvent contractée par les mineurs.
- l'empoisonnement au plomb et ses effets secondaires, de même que l'empoisonnement causé par d'autres métaux ou substances (arsenic, mercure, phosphore).

En 1926, la silicose et la pneumoconiose, des maladies pulmonaires causées par l'inhalation de silice, de charbon, d'amiante et de poussières de talc, ont été ajoutées à l'annexe 3.

La même année, la CAT a accepté les premières demandes d'indemnisation relatives à ces maladies.

Jusqu'en 1947, seules les maladies de l'annexe 3 pouvaient être réputées professionnelles.

Cette année-là, le champ d'application de la Loi a été élargi pour que le terme «maladie professionnelle» s'applique à toute «maladie particulière à un procédé, un métier ou une profession donnée dans une industrie, ou qui est caractéristique». Par conséquent, la CAT a commencé à élaborer des politiques et des directives visant à déterminer l'admissibilité des travailleurs à des indemnités pour de nouvelles maladies professionnelles, comme la déficience auditive due au bruit (DADB), la DADB est la perte d'acuité auditive permanente dans les deux oreilles associée à une surdité de perception (atteinte de l'oreille interne) résultant d'une exposition prolongée et continue à des bruits dangereux.

En 1963, le législateur a reconnu que des périodes cumulatives d'exposition à des agents présents dans le lieu de travail pouvaient causer des maladies et il a ajouté la

## Annexe 4

notion «d'incapacité» à la Loi. En vertu du paragraphe 1 (1) de la Loi, «accident» comprend «l'incapacité survenant du fait et au cours de l'emploi». Dans la politique 03-01-01 du Manuel des politiques opérationnelles, «l'incapacité» est ainsi défini :

- l'état qui apparaît progressivement
- le résultat inattendu des tâches d'emploi.

Durant les années 1970 et 1980, nous avons été de plus en plus sensibilisés aux maladies professionnelles. Par exemple, la Commission Ham a recommandé qu'une étude

Ces études épidémiologiques ont mis en lumière un certain nombre de maladies professionnelles présentes chez les mineurs, notamment le cancer du poulmon, la silicose et les maladies découlant d'une exposition à des radiations.

En 1984, la Commission royale d'enquête sur les questions de santé et de sécurité soulevées par l'utilisation de l'amiante en Ontario a établi que l'amiantose, le mésothéliome (cancer touchant la surface des poulmons et des cavités abdominales), le cancer du poulmon, le cancer du larynx et le cancer gastro-intestinal étaient des maladies professionnelles attribuables à une exposition à de l'amiante. En conséquence, la CAT a reconnu que ces maladies étaient des maladies professionnelles, et elle a élaboré des politiques à ce sujet, en plus d'émettre des recommandations afin de modifier la Loi (voir les documents 04-04-05, 04-04-15, 04-04-16, 04-04-13, et 04-04-14 du manuel des politiques).

À la même époque, Paul Weiler, spécialiste du droit relatif à l'indemnisation des travailleurs à l'Université Harvard, a écrit une série de rapports portant sur l'indemnisation des travailleurs en Ontario. Il a recommandé que l'on modifie la définition de «maladie professionnelle» et que l'on mette sur pied le Comité des normes en matière de maladies professionnelles (CNMMP). Ce comité fait des recommandations à la CAT au sujet des nouvelles maladies professionnelles devant être reconnues et des critères devant être utilisés pour déterminer l'admissibilité. La dernière recommandation du comité, qui a donné lieu à l'adoption d'une nouvelle politique (n° 04-04-22), portait sur la sclérodermie.

La page 5 contient des notes biographiques sur les membres du CNMMP. Voir aussi le *Bulletin des politiques*, vol. 6, n° 4.

Colonne 1 Maladie	Colonne 2 Travail effectué
1. Amiantose	Travail d'exploitation minière, de meunerie, de fabrication, d'assemblage, de construction, de réparation, de transformation, d'entretien ou de démolition comportant la production de fibres d'amiante en suspension dans l'air.
2. Néoplasme malin primaire du mésothélium de la plèvre du péritoine	Travail d'exploitation minière, de meunerie, de fabrication, d'assemblage, de construction, de réparation, de transformation, d'entretien ou de démolition comportant la production de fibres d'amiante en suspension dans l'air.
3. Cancer primitif des fosses nasales ou des sinus de la face	Tout procédé en application à l'usine de frittage d'INCO limitée à Copper Cliff.
4. Cancer primitif des fosses nasales ou des sinus de la face	Tout procédé en application au département de lixivation, de calcination ou de frittage d'INCO limitée à Port Colborne tel qu'il a été utilisé avant 1966.

épidémiologique soit effectuée tous les cinq ans chez les travailleurs du secteur minier. L'épidémiologie professionnelle est une science qui a pour but :

- de déterminer et d'évaluer les causes des maladies
- de mesurer la fréquence des maladies
- de fixer des limites quant à la durée des expositions
- d'étudier les façons de prévenir et de contrôler les maladies.

3. Preventing Occupational Disease and Injury, James L. Weeks, Barry S. Levy, and Gregory R. Wagner, eds, American Public Health Association, 1991, p. 36.

Annexe 3

Colonne 1 Maladie	Colonne 2 Travail effectué
xiii. nitro- et amino-dérivé de benzène, du phénol et de leurs homologues (trinitrotoluène, dinitrophénol, aniline et autres)	Manipulation des substances ci-contre ou travail consacré à leur fabrication ou comportant l'emploi de ces produits
xiv. vapeur nitreuse	Procédé comportant l'émanation de vapeurs nitreuses
xv. phosphore	Travail comportant l'emploi de phosphore ou de ses préparations ou composés
8. Pneumoconiose autre que la silicose	
9. Maladie provoquée par l'exposition aux rayons X, au radium ou à d'autres substances radioactives	
10. Maladie respiratoire provoquée par l'inhalation de substances utilisées dans l'atomisation non-offset	Procédé ou travail comportant l'atomisation non-offset dans l'imprimerie
11. Rétinite provoquée par le soudage à l'arc ou à l'acétylène	
12. Silicose	Exploitation minière, extraction, taille, broyage, meulage ou polissage de la pierre; meulage ou polissage métalliques
13. Ténosynovite	
14. Tuberculose contractée par un employé employé par :	
i. un hôpital, une prison, un sanatorium, une maison de convalescence, une maison de soins infirmiers, un foyer pour personnes âgées, une circonscription sanitaire ou une association d'infirmière visiteuse auxquels s'applique la partie I de la Loi;	
ii. un laboratoire, un centre d'éducation surveillée, une circonscription sanitaire ou un centre de traitement dont le fonctionnement est assuré par la province de l'Ontario	
15. Ulcération de la cornée provoquée par le goudron, le brat, le bitume, l'huile minérale, la paraffine, ou un composé, produit ou résidu de ces substances	Manipulation ou utilisation des substances ci-contre ou de leurs composés, produits ou résidus
16. Cancer primitif des fosses nasales ou des sinus de la face	Concentration, fusion ou raffinage dans l'industrie de la production du nickel

Les maladies professionnelles «véritables» et celles ayant des causes multiples

Certains scientifiques répartissent les maladies professionnelles en deux catégories : les maladies «véritables» et les maladies ayant des causes multiples. Les maladies professionnelles «véritables» sont celles dont la cause se trouve surtout dans le lieu de travail. L'amiantose, maladie pulmonaire provoquée par l'inhalation de grandes quantités de particules d'amiant, est considérée comme une maladie professionnelle «véritable» parce que, si une personne en est atteinte, ce ne peut être que parce qu'elle a travaillé dans un lieu où il y avait de l'amiant. Dans le cas des maladies ayant des causes multiples, il faut obtenir plus de précisions sur la profession du travailleur et l'industrie dans laquelle il travaille avant de pouvoir établir si la maladie peut être réputée professionnelle.

Évolution de la Loi en ce qui concerne les maladies

À mesure que les milieux scientifiques et médicaux acquièrent de nouvelles connaissances sur les maladies, la Loi est modifiée afin que de plus en plus de maladies soient réputées de nature professionnelle.

En 1913, sir William Meredith, fondateur du régime d'indemnisation des travailleurs de l'Ontario, a déclaré :  
[...] en ce qui a trait au droit des travailleurs à des indemnités, les maladies professionnelles sont sur le même pied que les accidents. [...] À mon avis, cela constituerait un outrage au sens même de la Loi si un travailleur ayant contracté une maladie professionnelle au cours de son emploi n'avait pas droit à des indemnités. Le risque de contracter la maladie est inhérent à l'emploi qu'il occupe et il ne peut pratiquement pas se prémunir contre un tel risque.

Lorsque la Loi est entrée en vigueur en 1915, il était passablement facile d'établir

2. Mulland, R.J., et Murphy, L.L., Occupational sentinel health events: An up-dated list for physician recognition and public health surveillance. American Journal of Industrial Medicine, 1991, p. 775-799.



périodes d'exposition cumulatives à l'agent causal. Ces maladies se manifestent lorsque les effets nocifs d'une exposition répétée à un agent causal s'accumulent. C'est le cas, par exemple, de la maladie des vibrations, qui découle d'une exposition à des vibrations, et du syndrome du canal carpien, qui résulte de mouvements répétitifs.

### Causalité

Pour établir si une maladie résulte d'une exposition particulière, les scientifiques évaluent la preuve qui ressort de plusieurs études. Pour faciliter cette évaluation, ils utilisent souvent les «critères de Bradford Hill»<sup>1</sup>, dont les suivants :

- **L'étroitesse du lien entre l'exposition et la maladie**  
Quel est le risque associé à une profession ou à une exposition particulière?

- **La constance de ce lien**  
Existe-t-il plusieurs études qui font état de résultats similaires?

- **La temporalité**  
En ce qui a trait à la séquence des événements, les études démontrent-elles que l'exposition est survenue avant la maladie?

- **Le gradient biologique**  
L'exposition accrue à l'agent causal augmente-t-elle le risque de contracter la maladie?

- **La plausibilité biologique**  
Le lien entre l'exposition et la maladie est-il plausible, compte tenu des connaissances actuelles relatives aux principes de la biologie?

Il n'est pas essentiel que tous ces critères scientifiques soient respectés ; toutefois, plus il y a de critères qui **sont** respectés, pourront vraisemblable que les scientifiques pourront établir un lien de causalité entre la profession et la maladie.

1. Bradford Hill, A., The environment and diseases: Association or Causation. Proceedings of the Royal Society of Medicine 1965, 58: 295-300.

Colonne 1 Maladie	Colonne 2 Travail effectué
1. Anthrax	Manipulation de la laine, du crin, du poil, du cuir, des peaux
2. Ampoule infectée	Travail comportant une friction continue
3. Bursite	
4. Tumeur épithéliale ou ulcération de la peau provoquée par le goudron, le brai, le bitume, l'huile minérale, la paraffine, ou un composé, produit ou résidu de ces substances	Manipulation ou utilisation des substances ci-contre ou de leurs composés, produits ou résidus
5. Mal dû à l'air comprimé ou mal des caissons	Travail effectué dans un milieu où l'air est comprimé
6. Eczéma de contact	
7. Empoisonnement causé par les substances suivantes, et suites :	
I. arsenic	Travail comportant l'emploi d'arsenic ou de ses préparations ou composés
II. benzol	Travail comportant l'emploi de benzol
III. béryllium	Travail comportant l'emploi de béryllium ou de ses préparations ou composés
IV. cuivre, nickel ou zinc	Travail comportant l'emploi de nickel ou de cuivre, ou la fonte ou l'affinage du zinc
V. cadmium	Travail comportant l'emploi de cadmium ou de ses préparations ou composés
VI. sulfure de carbone	Travail comportant l'emploi de sulfure de carbone ou de ses préparations ou composés
VII. gaz carbonique	Travail comportant l'émanation de gaz carbonique
VIII. monoxyde de carbone	Travail comportant l'émanation de monoxyde de carbone
IX. hydrocarbure chloré (tétrachlorure de carbone, trichloréthylène, trichloronaphtalène et autres)	Travail comportant la fabrication ou l'emploi des substances ci-contre
X. chrome	Travail comportant l'emploi de chrome ou de ses composés
XI. plomb	Travail comportant l'emploi de plomb ou de ses préparations ou composés
XII. mercure	Travail comportant l'emploi de mercure ou de ses préparations ou composés



## Maladies professionnelles

Environ 5 pour cent des quelque 370 000 demandes d'indemnisation enregistrées en Ontario en 1993 avaient trait aux maladies professionnelles. Bien que ce pourcentage puisse paraître faible, ces demandes comptent parmi les plus difficiles et les plus longues à traiter. Dans le présent *Bulletin des politiques*, nous définirons le terme «maladie professionnelle», nous expliquerons pourquoi les demandes d'indemnisation pour maladie professionnelle sont difficiles à traiter et nous ferons l'histoire de la notion de maladie professionnelle en ce qui a trait au régime d'indemnisation des travailleurs de l'Ontario.

### Qu'entend-on par «maladie professionnelle»?

Les scientifiques travaillant dans le domaine de la santé au travail considèrent qu'une maladie est «professionnelle» lorsqu'elle découle du travail. L'Organisation internationale du Travail (OIT) définit «maladie professionnelle» ainsi : tout état pathologique, c'est-à-dire tout état découlant d'un problème physique, qui résulte d'un travail prolongé. Fondée en 1919, l'OIT est une agence spécialisée de l'Organisation des Nations Unies, qui est composée de représentants des gouvernements, des employeurs et des travailleurs de 146 pays.

Au paragraphe 1 (1) de la *Loi sur les accidents du travail* (la *Loi*), le terme «maladie professionnelle» est défini ainsi :

(a) une maladie résultant d'une exposition à une substance liée à un procédé, un métier ou une profession donnés dans une industrie,

(b) une maladie particulière à un procédé, un métier ou une profession donnés dans une industrie, ou qui en est caractéristique,

(c) un état médical qui, selon la Commission, exige que l'exposition d'un travailleur à une substance cesse temporairement ou de façon permanente, parce que l'état peut être annonciateur d'une maladie professionnelle,

(d) une maladie mentionnée à l'annexe 3 ou 4.

Contrairement à l'OIT, la *Loi* reconnaît non seulement les maladies causées par un travail prolongé, mais également les maladies

### Comment les scientifiques décrivent-ils les maladies?

résultant d'expositions aiguës reliées au travail.

Dans les milieux scientifiques, il est reconnu que le laps de temps qui s'écoule entre l'exposition à l'agent responsable de la maladie et l'apparition de celle-ci constitue l'une des façons permettant de décrire une «période de latence». L'apparition de certaines maladies est **immédiate**, tandis que dans d'autres cas, une longue période peut s'écouler entre l'exposition à l'agent causal et l'apparition des symptômes physiques. Dans le cas de telles maladies, on dit que l'apparition est **retardée**.

### Maladies dont l'apparition est immédiate

Les causes de ces maladies sont les plus faciles à déceler. Pour les scientifiques et les praticiens qui effectuent ce «travail de dépistage», de même que pour les décideurs de la CAT qui doivent établir si une maladie est reliée au travail, les indices sont là : le lieu, le moment, l'activité, l'exposition à un agent et l'apparition immédiate des symptômes physiques. Certaines maladies professionnelles énumérées à l'annexe 3 de la *Loi* appartiennent à la présente catégorie, l'empoisonnement et l'ulcération de la cornée.

### Maladies dont l'apparition est retardée

Il est beaucoup plus difficile d'identifier la cause de ces maladies. En effet, comme ces

maladies ne se manifestent pas immédiatement après l'exposition, la preuve nécessaire pour déterminer leur cause et leurs effets peut ne pas être évidente, ou la situation peut être compliquée par d'autres facteurs. Par exemple, il peut y avoir à la fois des facteurs professionnels et non professionnels qui contribuent à l'apparition et à l'évolution de la maladie. De plus, même si les scientifiques peuvent être en mesure d'établir que certains groupes de travailleurs risquent fortement de contracter une maladie donnée, les spécialistes du domaine médical ne peuvent être absolument certains que le lieu de travail constitue un facteur ayant contribué de façon importante à l'apparition de la maladie chez le travailleur. Par exemple, dans le cas du cancer du poumon chez un travailleur des mines d'or, la maladie est la même, qu'elle ait été causée par des agents présents dans le lieu de travail ou par le tabagisme.

Les maladies dont l'apparition est retardée comprennent les **maladies à longue période de latence** et les **maladies résultant de périodes d'exposition cumulatives**.

### • Maladies à longue période de latence

Une maladie pourrait tarder à apparaître si elle est caractérisée par une longue période de latence. L'expression «longue période de latence» signifie qu'une longue période s'écoule entre l'exposition ayant causé la maladie et l'apparition des signes extérieurs de celle-ci. Le cancer constitue un exemple de maladie à longue période de latence.

### • Maladies résultant de périodes d'exposition cumulatives

Une maladie peut également tarder à apparaître si elle est attribuable à des



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## POLICY REPORT

Workers'  
Compensation  
BoardCommission  
des accidents  
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Vol. 7 No. 4

## Hand-arm vibration syndrome (HAVS) - Determining permanent impairment

On January 28, 1994, the board of directors of the WCB approved medical guidelines for determining how to rate the permanent impairment of workers who have hand-arm vibration syndrome (HAVS).

HAVS falls into the category of a delayed onset, cumulative exposure disease (see *Policy Report* Vol. 7 No. 3). Originally recognized by the WCB in 1978 and, at that time, known as "white finger disease," HAVS can affect individuals working with hand-held vibrating tools. The original name for the disease was a result of one of the earliest recognized features: the disease affects fingertips, turning them white when exposed to cold temperatures. The condition has also been called "chippers syndrome," "wax or dead fingers," "Traumatic Vasospastic Disease (TVD)," and "Raynaud's Phenomenon of Occupational Origin."

### Work-related cause

Since HAVS is caused by vibration, workers in industries such as mining, forestry, and automotive assembly who use vibrating tools may be the most likely, over time, to develop HAVS. The tools most commonly associated with vibration include

- pneumatic tools (i.e., diamond drills)
- pneumatic hammers
- rotary burring tools and chisels
- (hand held/pedestal) grinders
- metal swaging or trimming tools
- chain/power saws
- jackhammers
- riveters.

### Symptoms

Scientists and medical professionals do not know exactly why vibration causes

this condition, but the symptoms are well-known and fall into the following categories: vascular, neurological, and/or musculoskeletal.

- The **vascular** component consists of vasospasm: the blood vessels go into spasm, making the inside of the vessels constrict or become smaller, and incapable of carrying enough blood. This causes blanching, or the "white finger" effect, which is accompanied by stiffness, numbness, and pain.<sup>1</sup> These symptoms are usually brought on by exposure to cold temperatures and, sometimes, dampness.
- **Neurological** impairment consists of decreased touch sensitivity and decreased manual dexterity.
- **Musculoskeletal** symptoms include muscle fatigue and declining grip strength.

In the early stages of HAVS, the worker may experience occasional periods of tingling and/or numbness in the fingers, and sometimes pain and blanching. But, if the cause of the disease (vibration) is removed, some recovery may occur. If the worker, however, continues to use vibratory tools, the symptoms become worse. For example, workers may have cold fingers **even** in warm weather.

### AMA Guides

Section 15(1) of Regulation 1102 of the *Workers' Compensation Act* directs the WCB to use the American Medical Association *Guides to the Evaluation of Permanent Impairment* (AMA Guides) to

## Industrial disease and secondary conditions

On March 25, 1993, the Industrial Disease Standards Panel (IDSP) provided the WCB with Report No. 11 entitled "Respiratory Complications Among Workers Receiving Compensation for Non-malignant Respiratory Disease." That report raised a number of important issues concerning the recognition of secondary impairments resulting from work-related disease or injury. In particular, it noted the importance of informing stakeholders that the WCB's *Operational Policy* manual document 03-04-02 relates to both injury by accident and industrial disease.

Document 03-04-02 on secondary conditions resulting from work-related disability states:

"Workers sustaining secondary conditions that are causally linked to the work-related injury will derive benefits to compensate for the further aggravation of the work-related disability or for new injuries."

This means that, for example, if a work-related right knee injury causes the worker to rely more heavily on the left knee, straining the left knee, the worker may be entitled to benefits for the left knee injury.

A number of examples are given in this policy (03-04-02) for injury by accident. But, there is also strong scientific evidence that supports the conclusion that certain secondary conditions are the result of recognized industrial diseases (e.g., tuberculosis as a secondary condition to silicosis).

continued on page 2

continued on page 4

# HAVS... (continued from page 1)

determine a worker's level of impairment when calculating a non-economic loss (NEL) benefit. The *AMA Guides* is a reference book that describes medical and scientific procedures for determining permanent impairment for injuries and diseases. The *AMA Guides* takes what is referred to as the "whole person" approach to rating permanent impairments, since any impairment affects an individual as a whole. Using this approach, it is necessary first to find the degree to which an injury or disease has impaired each part of the body. The next step is to combine the separate ratings using the "Combined Values Chart" to establish the degree to which the "whole person" is impaired.

However, the *AMA Guides* does not provide a rating specifically for impairment due to HAVS, so the WCB relies on s.15(2) of Regulation 1102 of the *Act* which states:

"When determining the degree of a worker's permanent impairment for a type of impairment not listed in the rating schedule, the Board shall consider the listing in the schedule for those body parts, systems or functions which are most analogous to the conditions of the worker."

In other words, if the WCB wants to rate a worker's permanent impairment (caused by an occupational disease such as HAVS) that is **not** specifically covered in the *AMA Guides*, it looks at the impairments in the *AMA Guides* that are most similar to the worker's. For example, with HAVS, NEL decision-makers use the section in the *AMA Guides* that deals with rating hand injuries, determining the degree of vascular, neurological, and musculoskeletal impairment of the hands. If other parts of the body are affected, these, too, are rated.<sup>2</sup>

## Rating Permanent Impairment

Once a worker affected by HAVS reaches maximum medical rehabilitation (MMR)—

see *Operational Policy (OP)* manual document 05-03-11—the NEL roster physician<sup>3</sup> takes a detailed clinical and non-clinical medical history, and conducts a complete physical examination including appropriate lab tests and diagnostic procedures, and prepares a report on the worker's condition, detailing each of the separate components (vascular, neurological, and musculoskeletal).

The WCB NEL decision-maker considers the roster physician's report and, using the section in the *AMA Guides* dealing with the parts of the body affected, rates each aspect of the condition individually and then calculates the whole body impairment using the appropriate charts in the *AMA Guides*. For more information about the process of rating permanent impairment in HAVS claims, see the chart on page 3.

## Benefits

As with other injured workers, those with HAVS may be entitled to

- temporary total or temporary partial disability benefits if they are temporarily disabled
- vocational rehabilitation if, in the opinion of the WCB, their medical condition requires that temporarily or permanently they must not use hand-held vibrating tools
- a non-economic loss (NEL) benefit based on the level of impairment caused by the disease (see *OP* manual document 05-06-01)
- a future economic loss (FEL) benefit for any economic loss resulting from the disease.

## SIEF

In HAVS claims, employers may be entitled to some cost relief under the Second Injury and Enhancement Fund (SIEF). See *OP* manual document 08-01-05 for more information.

## Notes:

- 1 Some workers may not have these symptoms.
- 2 In some occupations, workers' feet may be affected by vibration. In these cases the section in the *AMA Guides* dealing with the lower extremities (feet/legs) is used and the ratings are combined with those for the hands.
- 3 To be examined for a NEL rating, a worker must choose a physician from a roster provided by the WCB. (For more information about NEL roster physicians see *OP* manual document 05-06-02 and *Policy Report* Vol. 4 No. 5.)



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## Policy Report

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**Comments or inquiries should be addressed to:**

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# HAVS... (continued)

## Evaluating impairments associated with HAVS

Process	Test results provided to roster physician	Information required in roster physician's report	AMA Guides table No.
<p>1. Assess peripheral vascular impairment of the upper extremity (hands and arms).</p> <p>Do not assess hands separately.</p>	<ul style="list-style-type: none"> <li>- finger re-warming</li> <li>- digital blood pressure</li> <li>- digital plethysmography</li> </ul>	Frequency and intensity of symptoms; effect on Activities of Daily Living (ADL); results of laboratory tests; number and extent of fingers affected; controllability by type of medication.	Table 16
2. Convert to impairment of the whole person, attributable to peripheral vascular disorder.			Table 3
<p>3. Assess neurological impairment of each arm.</p> <p>Use results from worse arm.</p>	<ul style="list-style-type: none"> <li>- aesthesiometer</li> <li>- vibration perception threshold</li> <li>- Phalen's test</li> <li>- Tinel's test</li> <li>- appropriate electrodiagnostic studies, (i.e., electromyography, nerve conduction velocity)</li> </ul>	Test results to characterize the symptoms and severity of neuropathy; frequency and intensity of symptoms; muscle weakness/wastage; proportion of limb affected; effect on ADL.	Table 10 and Table 14, Combined Values Chart (used to combine findings within the more affected upper extremity)
4. Convert to impairment of the whole person, attributable to upper body neurological impairment.			Table 3
<p>5. Assess musculoskeletal impairment (loss of strength) in each arm.</p> <p>If <b>one</b> arm is affected, compare results with those of unaffected arm. If <b>both</b> arms are affected, compare results with data in the AMA Guides tables.</p>	<ul style="list-style-type: none"> <li>- Jamar dynamometer results</li> <li>- grip and pinch tests</li> </ul>	Jamar dynamometer testing results and effect on ADL	Calculation of percentage strength index using Tables 20, 21, and 23, Combined Values Chart
6. Convert to impairment of the whole person, attributable to loss of strength.			Table 3
7. Derive total impairment of the whole person due to HAVS using values from steps 2, 4 and 6.			Combined Values Chart

# New Employer Registration Team

The Employer Registration and Assessment Branch recently restructured its operations to improve customer service.

Effective May 30, 1994, a new head office team, known as the Employer Registration Team, will concentrate its efforts solely on

- registering new employers
- closing employer accounts
- re-opening employer accounts
- handling enquiries regarding Schedule 1 and 2 transfers.

The Employer Registration Team will also handle all incoming mail and walk-in interviews for employers wishing to open or close accounts.

This internal restructuring does not affect or change employers' reporting responsibilities. Stakeholders may still phone the Employer Registration and Assessment Branch at (416) 927-3925, or toll free, at 1-800-387-8638.

## Secondary conditions...

*continued from page 1*

However, there is no current WCB policy to recognize particular conditions as secondary to certain industrial diseases, or to exclude such relationships. Therefore, until specific WCB policies are in place, the work relationship between the secondary condition and the industrial disease continues to be determined on a case-by-case basis.

The *Workers' Compensation Act* requires the WCB to respond to the findings contained in IDSP reports. The board of directors approved a response to the IDSP report on non-malignant respiratory disease on February 15, 1994. The response, published in *The Ontario Gazette* on April 2, 1994, requests the Panel to clarify its findings.

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# Inscription des employés

Récemment, la Direction de l'inscription des employés et des cotisations restructurait ses activités afin d'améliorer la prestation des services aux clients.

Depuis le 30 mai 1994, une nouvelle équipe du Bureau central, désignée sous le nom d'équipe chargée de l'inscription des employés, fait porter ses efforts uniquement sur les activités suivantes :

- l'inscription des nouveaux employés;
- la fermeture des comptes d'employés;
- la réouverture des comptes d'employés;
- le traitement des demandes portant sur les transferts entre les annexes 1 et 2.

L'équipe se charge également de traiter tout le courrier d'arrivée et de recevoir en entrevue les employés qui se présentent sans rendez-vous au Bureau central dans le but d'ouvrir ou de fermer un compte.

Cette restructuration interne n'influe aucunement sur les responsabilités des employés en ce qui concerne la déclaration. De plus, les personnes et groupes intéressés peuvent toujours communiquer, à ce sujet, avec la Direction de l'inscription des employés et des cotisations au (416) 927-3925 ou, sans frais, au 1-800-387-8638.

## Avez-vous changé d'adresse?

Afin de nous assurer que vous recevez chaque numéro du Bulletin des politiques et de garder nos frais de poste à la baisse, nous devons tenir notre liste d'envoi à jour. Veuillez donc communiquer tout changement d'adresse au :

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## Troubles secondaires...

(suite de la page 1)

Plusieurs exemples de lésions accidentelles sont donnés dans le document 03-04-02. Mais il existe aussi des preuves scientifiques solides permettant de conclure que certains troubles secondaires sont le résultat de maladies professionnelles reconnues (p. ex., la tuberculose qui serait secondaire à la silicose).

Cependant, il n'existe actuellement pas de politique à la CAT permettant de reconnaître certains troubles comme étant secondaires à certaines maladies professionnelles, ou d'exclure un tel lien. Par conséquent, dans l'attente de politiques précises, le lien professionnel entre les troubles secondaires et les maladies professionnelles continuera d'être déterminé selon chaque cas pris individuellement.

En vertu de la *Loi sur les accidents du travail*, la CAT est tenue de donner suite aux conclusions énoncées dans les rapports du CNMMP. Le 15 février 1994, le conseil d'administration a approuvé la réponse de la CAT au rapport du CNMMP sur les maladies respiratoires bénignes. Dans sa réponse, publiée dans la *Gazette de l'Ontario* le 2 avril 1994, la CAT a demandé au comité de clarifier ses conclusions.

## Bulletin des politiques

Le **Bulletin des politiques** est publié par la Direction des politiques sur l'indemnisation de la Commission des accidents du travail. S'il y a contradiction entre le texte de la présente publication et la *Loi sur les accidents du travail* et/ou les politiques approuvées de la Commission, c'est à la *Loi* ou aux documents approuvés qu'il faut se référer.

Veuillez adresser vos questions ou commentaires à la :

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## Evaluation de la déficience liée au syndrome vibratoire

<b>Méthode</b>	<b>Résultats d'épreuves fournis au médecin du tableau</b>	<b>Renseignements requis dans le rapport du médecin du tableau</b>	<b>Tableau des guides de l'AMA</b>
1. Évaluer l'atteinte des vaisseaux périphériques des membres supérieurs (mains et bras).  Ne pas évaluer les mains séparément.	<ul style="list-style-type: none"> <li>- Réchauffement des doigts</li> <li>- Pression artérielle digitale</li> <li>- Pléthysmographie digitale</li> </ul>	Fréquence et intensité des symptômes; effet sur les activités de la vie quotidienne (AVQ); résultats des tests de laboratoire; nombre de doigts touchés et étendue des troubles; suppression possible des symptômes par type de médicaments.	Tableau 16
2. Convertir en fonction de l'atteinte des vaisseaux périphériques, affectant la personne globale.			Tableau 3
3. Évaluer l'atteinte neurologique pour chaque bras.  Utiliser les résultats relatifs au bras le plus gravement atteint.	<ul style="list-style-type: none"> <li>- Aesthésiomètre</li> <li>- Seuil de perception des vibrations</li> <li>- Manoeuvre de Phalen</li> <li>- Signe de Tinel</li> <li>- Épreuves électrodiagnostiques appropriées (c.-à-d. électromyographie, vitesse de conduction nerveuse)</li> </ul>	Résultats d'épreuves permettant de préciser les symptômes et la gravité de la neuropathie; fréquence et intensité des symptômes; faiblesse ou atrophie musculaire; proportion du membre atteint; effet sur les AVQ.	Tableaux 10 et 14 ainsi que le tableau d'évaluation combiné (servant à combiner les constatations se rapportant au membre supérieur le plus gravement atteint).
4. Convertir en fonction de l'atteinte neurologique touchant le haut du corps, affectant la personne globale.			Tableau 3
5. Évaluer l'atteinte musculo-squelettique (perte de force) pour chaque bras.  Si seulement un bras est atteint, comparer les résultats obtenus avec ceux se rapportant à l'autre bras. Si les deux bras sont atteints, comparer les résultats obtenus avec les données figurant dans les guides de l'AMA.	<ul style="list-style-type: none"> <li>- Résultats obtenus au moyen du dynamomètre Jamar</li> <li>- Résultats mesurant la force de préhension</li> </ul>	Résultats obtenus au moyen du dynamomètre Jamar et effet sur les AVQ.	Calcul du pourcentage de l'indice de force au moyen des tableaux 20, 21 et 23, ainsi que du tableau d'évaluation combiné.
6. Convertir en fonction de l'atteinte attribuable à la perte de force, affectant la personne globale.			Tableau 3
7. Calculer, au moyen des valeurs obtenues aux étapes 2, 4 et 6, l'ensemble de la déficience touchant la personne globale.			Tableau d'évaluation combiné



dans les doigts, et parfois même de la douleur; de plus, les doigts peuvent également pâlir. Lorsque la cause de la maladie est éliminée (exposition aux vibrations), un certain rétablissement peut se produire. Cependant, si le travailleur continue d'utiliser des outils vibrants, les symptômes s'intensifient. Ainsi, des travailleurs atteints de la maladie peuvent avoir froid aux doigts même par temps chaud.

### Guides de l'AMA

Selon le paragraphe 15 (1) du Règlement 1102 de la Loi sur les accidents du travail, l'American Medical Association («AMA Guides to the Evaluation of Permanent Impairment») pour déterminer le degré de déficience d'un travailleur, au moment du calcul d'une indemnité pour perte non économique (PNE). Ces guides, contenus dans un document de référence, décrivent les actes médicaux et méthodes scientifiques à observer afin de déterminer le degré de déficience permanente rattaché aux lésions et aux maladies. Les guides de l'AMA suivent une approche axée sur le concept de la «personne globale» dans l'évaluation de la déficience permanente, étant donné que la déficience influe sur l'ensemble de la personne qui en est atteinte. Selon cette approche, il faut établir en premier lieu, pour chaque partie du corps, quel est le degré de déficience occasionné par la lésion ou la maladie. Puis, on combine les taux distincts en utilisant le tableau d'évaluation combiné pour obtenir le degré de déficience qui affecte la «personne globale».

Cependant, comme les guides de l'AMA ne renferment pas de taux de déficience s'appliquant expressément au syndrome vibratoire, la CAT se base sur le par. 15 (2) du Règlement 1102 de la Loi, qui prévoit que :

«Pour déterminer le degré de déficience permanente d'un travailleur relativement à un genre de déficience qui ne figure pas dans le barème de taux, la Commission tient compte des éléments du barème pour les parties,

systèmes ou fonctions du corps qui se rapprochent le plus de l'état du travailleur.» (Version provisoire.)

Autrement dit, si la CAT veut déterminer le degré de déficience permanente d'un travailleur atteint d'une maladie professionnelle (comme le syndrome vibratoire) qui n'est pas expressément nommée dans les guides de l'AMA, elle considère les déficiences qui ressemblent le plus à celle du travailleur. Par exemple, lorsqu'un travailleur est atteint du syndrome vibratoire, les décideurs chargés des cas de PNE peuvent se reporter à la section des guides qui traite des lésions aux mains, et ainsi déterminer le degré de déficience vasculaire, neurologique et musculo-squelettique du travailleur. Si la déficience se rapporte à une autre partie du corps, on fait également une détermination pour cette partie du corps.

### Détermination du taux de déficience permanente

Lorsqu'un travailleur souffrant du syndrome vibratoire atteint le stade de la réadaptation médicale maximum (RMM) - voir le document 05-03-1 du *Manuel des politiques opérationnelles de la CAT* - le médecin du tableau pour la PNE note en détail les antécédents médicaux cliniques et non cliniques du travailleur, lui fait subir un examen physique complet, y compris les tests de laboratoire et les épreuves diagnostiques appropriées et il rédige un rapport sur l'état du travailleur, en fournissant des précisions sur chacune des atteintes observées (vasculaire, neurologique et musculo-squelettique).

Le décideur de la CAT chargé des cas de PNE examine le rapport du médecin du tableau et, en se reportant à la section des guides de l'AMA qui traite de la partie du corps touchée, il détermine le taux de déficience se rapportant à chaque aspect de la maladie, puis il calcule le degré total de déficience en se basant sur les tableaux qui figurent dans les guides. Voir le tableau à la page 3 pour obtenir plus de renseignements sur la méthode d'évaluation de la déficience reliée au syndrome vibratoire.

### Indemnités

Comme c'est le cas pour les autres travailleurs blessés, le travailleur atteint du syndrome vibratoire peut avoir droit :

- à des indemnités d'invalidité totale ou partielle temporaire s'il a une invalidité temporaire;
- à des services de réadaptation professionnelle si, de l'avis de la Commission, son état exige qu'il évite d'utiliser des outils vibrants de façon temporaire ou permanente;
- à une indemnité pour perte non économique (PNE), selon le degré de déficience découlant de la maladie (voir le document 05-06-01 du manuel des politiques);
- à une indemnité pour perte économique future (PEF) s'il subit une perte économique en raison de la maladie.

### FGTR

Dans le cas des demandes

d'indemnisation se rapportant au syndrome vibratoire, l'employeur peut avoir droit à l'exonération d'une partie des coûts au titre du Fonds de garantie pour travailleurs réintégrés (FGTR). Voir le document 08-01-05 du manuel des politiques.

Notes :

1. Certains travailleurs peuvent ne pas avoir ces symptômes.
2. Dans certaines professions, les pieds des travailleurs peuvent être atteints. En pareil cas, on se reporte à la section des guides de l'AMA qui traite des membres inférieurs (pieds/jambes) et on combine les taux avec ceux qui s'appliquent aux mains.
3. Avant de subir une évaluation pour PNE, le travailleur doit choisir un médecin parmi ceux dont le nom figure au tableau des médecins au sujet du tableau des plus de précisions sur le document 05-06-02 du manuel des politiques, ainsi que le



## Syndrome vibratoire

### - Évaluation de la déficience permanente

### Maladies professionnelles et troubles secondaires

Le 28 janvier 1994, le conseil d'administration de la CAT approuvait des directives médicales visant à déterminer les pourcentages de déficience permanente des travailleurs atteints du syndrome vibratoire.

Ce syndrome fait partie de la catégorie des maladies résultant de périodes

d'exposition cumulatifs et dont l'apparition est retardée (voir *Bulletin des politiques*, vol. 7, n° 3). Reconnu pour la première fois par la CAT en 1978 et alors désigné «maladie des doigts blancs», le syndrome vibratoire peut frapper les travailleurs qui utilisent des outils à main

vibrants. Le nom que l'on donnait à l'origine à la maladie découlait de l'un des signes observés au départ chez ceux qui en étaient atteints; en effet, la maladie se manifestait au bout des doigts et, lorsqu'il y avait exposition au froid, elle rendait le

bout des doigts blanc. La maladie a également été appelée «syndrome de Chipper», «phénomène du doigt mort», «affection angiospastique traumatique» et «phénomène de Raynaud d'origine professionnelle».

### Cause reliée au travail

Comme la maladie est causée par les vibrations, les travailleurs utilisant des outils vibrants dans les mines, dans l'industrie forestière, ainsi que sur les chaînes de montage dans l'industrie de l'automobile, peuvent courir le plus grand risque de la contracter, à longue échéance. Parmi les outils les plus souvent associés aux vibrations, mentionnons :

- les outils pneumatiques (p. ex., les perforatrices à diamants);
- les marteaux pneumatiques;
- les outils de burinage et les ciseaux rotatifs;

- les broyeurs (manuels ou sur socle);
- les outils à étamper ou à ébarber le métal;
- les scies à chaîne ou les scies électriques;
- les marteaux perforateurs;
- les riveteuses.

### Symptômes

Les scientifiques et les professionnels de la santé ne savent pas quelle est la cause exacte de cette maladie, mais ils en connaissent bien les symptômes, qui sont de trois ordres : vasculaire, neurologique ou musculo-squelettique.

- Les symptômes de nature vasculaire se traduisent par des vasospasmes : spasmes des vaisseaux sanguins occasionnant un resserrement de l'intérieur des vaisseaux, ce qui empêche les vaisseaux de transporter le sang en quantité suffisante. Il y a alors blanchissement des doigts ou effet des «doigts blancs» accompagné de raideur, d'engourdissement et de douleur. Ces symptômes sont habituellement causés par l'exposition au froid et parfois, à l'humidité.

- Les symptômes de nature neurologique consistent en une diminution de la sensibilité tactile et de la dextérité manuelle.

- Les symptômes de nature musculo-squelettique comprennent la fatigue musculaire et une diminution de la force de préhension.

Aux stades initiaux de la maladie, le travailleur peut parfois ressentir des picotements et des engourdissements (suite à la page 2)

Le 25 mars 1993, le Comité des normes en matière de maladies professionnelles (CNMMP) présentait à la CAT son rapport n° 11 intitulé «Respiratory Complications Among Workers Receiving Compensation for Non-Malignant Respiratory Diseases» (Complications respiratoires chez les travailleurs qui reçoivent des indemnités pour des maladies respiratoires bénignes). Ce rapport a soulevé de nombreuses questions importantes relatives à la reconnaissance des troubles secondaires résultant d'une maladie ou d'une lésion reliées au travail. Le rapport a souligné, en particulier, qu'il était important d'informer les personnes et groupes intéressés que le document 03-04-02 du *Manuel des politiques opérationnelles de la CAT* se rapporte à la fois aux lésions accidentelles et aux maladies professionnelles.

Le document 03-04-02, qui traite des troubles secondaires résultant de l'invalidité reliée au travail, énonce que :

«Les travailleurs qui souffrent de troubles secondaires ayant un lien de causalité avec la lésion reliée au travail recevront des indemnités en raison de l'aggravation de l'invalidité reliée au travail ou de toute nouvelle lésion.»

Cela signifie, par exemple, que si un travailleur exerce une mise en charge plus prononcée sur son genou gauche, en raison d'une lésion au genou droit reliée au travail, et qu'il subit ainsi une entorse au genou gauche, il peut avoir droit à des indemnités pour ses troubles au genou gauche.

(suite à la page 4)



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# Policy Report



Workers'  
Compensation  
Board

Commission  
des accidents  
du travail

July 1994  
Vol. 7 No. 5

## Bulletin

### Future economic loss (FEL) sustainability benefits

*Here are the significant features of new and revised policies applied since June 1993. Refer to your Operational Policy (OP) manual for the full text of policies and guidelines. If you do not have a manual and would like to purchase one, call (416) 927-4941.*

In October 1993, the Board of Directors approved a change in the dollar amount of the FEL sustainability benefit. For initial FEL determinations or review decisions affecting entitlement to FEL benefits on or after December 1, 1993, the WCB pays sustainability benefits in the amount of \$1.00 per year. Before this change, the WCB paid sustainability benefits amounting to 1% of 90% of the worker's pre-accident net average earnings.

A sustainability benefit is not intended as compensation for a worker's wage loss. Instead, it allows the WCB to maintain the option of paying supplements [s.43(9)] until the next FEL review, if the worker is

- participating in a vocational rehabilitation program designed to fully replace pre-injury earnings

or

- not expected to sustain post-accident earnings that equal or exceed pre-injury earnings.

**(See 05-05-05, Initial Determination - Workers for whom a Vocational Rehabilitation Plan has been Developed; and 05-05-06, Workers Who are Earning at Time of Determination.)**

### Survivors' death benefits revised

If a worker suffers a severe injury such that the worker is entitled in one claim to total (100%) permanent disability benefits and subsequently dies, a survivor is entitled to the same compensation (death) benefits as if the worker had died at the time of the accident.

This guideline applies to

- claims with accident dates **before** January 2, 1990,

and

- decisions made affecting benefit periods in these claims on or after July 1, 1993.

**(See 05-03-10, Payments to Dependents.)**

### Wage loss for non-economic loss (NEL) medical assessments

Workers are entitled to wage loss benefits as a result of absence from work to attend NEL medical assessments. The amount of compensation depends on whether the workers are receiving FEL benefits.



## Wage loss for NEL medical assessments (cont'd)

- Workers who are **not** receiving FEL benefits are compensated for their loss of earnings under s.37 of the *Workers' Compensation Act* (the *Act*).
- Workers who **are** receiving FEL benefits are compensated for their loss of earnings under s.74 of the *Act*. They cannot be compensated under s.37 because s.37(1) precludes workers from receiving FEL benefits and temporary total disability benefits at the same time for the same injury/disease.

This policy applies to workers attending NEL assessments on or after July 4, 1994.

(See Transmittal 31 for 05-06-12, Wage Loss for NEL Assessment.)

## Relocation assistance

In December 1993, the Board of Directors amended the policy and guidelines dealing with relocation assistance to workers who find jobs outside their local areas and must relocate.

Effective March 1, 1994, the WCB pays relocation expenses if the worker finds a job outside the worker's local area as a result of an expanded job search required by the WCB, or that is agreed upon by the worker and caseworker.

In order to pay a worker's relocation expenses, WCB staff must now determine that the increase in the worker's long-term earnings potential—resulting from the new job—is greater than moving costs. WCB staff also must consider whether the relocation expenses are incurred in a responsible manner.

The following new criteria must be met before the WCB pays relocation expenses.

- The worker must commit to an actual permanent job that is compatible with appropriate rehabilitation objectives.
- The new workplace is 60 km or more from the worker's current home, and the new home is closer to the new workplace than the current home is by 40 km or more.
- The hiring employer is not financially assisting the worker. If the employer is financially assisting the worker but this assistance does not cover the worker's costs, the WCB pays the difference between the employer's assistance and WCB-allowed expenses.

(See 07-03-12, Relocation Assistance.)

## Section 48, garnishments

If a worker's spouse or dependants are entitled to support or maintenance under a court order, s.48 of the *Act* allows the WCB to make deductions from a worker's compensation benefits to honour the court order. The *Wages Act*, however, limits these deductions to 50% of any compensation benefits due to a worker, **unless** the court order specifies otherwise.

With the exception of funds set aside for retirement pensions under s.44(1), any monetary compensation under the *Act* is considered to be wages subject to garnishment.

This policy applies to all deductions related to Notices of Garnishment issued after April 1, 1985, which are ongoing after December 1, 1991.

(See 05-01-16, Section 48, Garnishments.)



## Employer compliance with the Act

The WCB makes every effort to encourage employers to comply with their obligations under the *Act*. On October 20, 1993, the Board of Directors approved policy and guidelines that detail the steps—in addition to existing administrative penalties—the WCB will take **before** prosecution for failure to comply can take place. For offences occurring on or after January 1, 1994, the WCB will usually prosecute employers only **after** efforts to encourage compliance have failed. If, however, the employer was convicted of an offence under the *Act* within the last 5 years, the WCB may start prosecution action immediately.

If an employer fails to comply with the *Act*, the WCB sends notices to the employer by registered mail for two consecutive months. The notices specify the

- offence
- date on which it was committed
- potential penalty
- action necessary to comply
- date by which the employer must comply.

Employers who do not comply by the date specified in the notices may be prosecuted. If convicted these employers may be fined up to the maximums, as listed in the chart following.

The Act	Description of the offence	Maximum fine for non-compliance
s.20(2)	Employer makes deductions from workers' wages for expenses for workers' compensation.	\$10,000
s.50(9)	Employer receives contributions from workers for health care expenses related to workers' compensation.	\$10,000
s.63(4)	Employer does not comply with rules of an approved accident prevention association.	\$10,000
s.71(8)	Employer or employer representative discloses medical information about a particular worker/case.	\$5,000
s.109(6)	Employer does not submit accurate payroll estimates and statements of wages when required.	\$25,000
s.111(3)	Employer does not submit accurate payroll records by authorized persons to ensure wages are reported correctly.	\$25,000
s.113(2)	Employer does not allow safety inspections of premises by authorized persons.	\$25,000
s.130(3)	Employer does not pay or give security for sufficient funds to pay assessments, in the case of an industry temporarily carried on.	\$25,000
s. 133(2)	Employer fails to report injury/disease within 3 days.	\$25,000

(See 08-08-03, Prosecution of Employers.)

## Post-judgement interest rates

The WCB pays interest on benefit payments issued after their standard payment due dates. The WCB pays interest at a rate equal to the Courts of Canada post-judgement interest rate.

The Courts of Canada set this rate quarterly under the *Courts of Justice Act*. The rate is the official Bank Rate—rounded up to the next higher whole number, plus 1 per cent. The interest rates are published quarterly in *The Ontario Gazette*. See also *Policy Report* Vol. 7, No. 1.

The interest rates for the second and third quarters of 1994 are 6% and 8%, respectively.

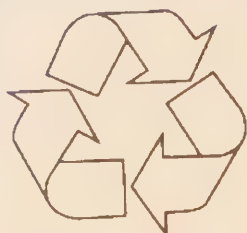
(See 05-01-08, Interest Payments.)

## Return to work certificates

The situation is a common one: the employer asks the worker for medical clearance—a return-to-work certificate—before allowing the worker to resume work. The worker sees the treating physician, obtains the certificate and returns to work. Who pays for this certificate, the WCB, OHIP, or the employer?

Since neither the *Act* nor the WCB requires workers to obtain such certificates, the WCB does not pay for them. OHIP does not cover the cost: the *Ontario Health Insurance Act* as amended in December 1993, makes the “3rd party” liable for the cost of the “uninsured document, information or service.” In this situation the return-to-work certificate is considered an uninsured document and the **employer** is considered the third party who pays for the certificate.

Regulations are currently being developed by the Ministry of Health to deal with this issue, and any inquiries should be directed to them at (416) 314-5518 or 1-800 268-1154.



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## Announcement

**International Ergonomics Association (IEA) Triennial Congress**  
**Toronto, August 15-19, 1994**

The IEA congress is an international forum for the exchange of ergonomics information. The program reflects the diversity of interests found within every field of ergonomics. Technical paper presentations, special sessions, panels, posters, and symposia make up the over 1,000 contributions from all over the world. Feature addresses by 24 keynote speakers will provide overviews in the major areas of specialization. Workshops and technical tours offer opportunities for professional development while introductory lectures will help orient and integrate those new to ergonomics.

For more information contact the IEA '94 Secretariat  
c/o JPdL Multi Management Inc.  
Toronto Dominion Centre  
55 King Street West, Suite 2550  
Toronto, Ontario M5K 1E7  
Telephone (416) 784-9396

## Policy Report

**Policy Report** is published under the authority and direction of the Benefits Policy Branch of the Workers' Compensation Board. If there is any conflict between the statements contained in this publication and the *Workers' Compensation Act* and/or Board-approved policy documents, the *Act* or the approved document governs.

**Comments or inquiries should be addressed to:**

Editor  
**Policy Report**  
Benefits Policy Branch  
Workers' Compensation Board  
2 Bloor Street East, 22nd Floor  
Toronto, Ontario M4W 3C3



# Taux d'intérêts

## postérieurs au jugement

La CAT paie des intérêts sur les indemnités dont le versement est effectué après la date à laquelle ces indemnités auraient normalement dû être versées. Le taux d'intérêt payé par la CAT correspond au taux d'intérêt postérieur au jugement fixé par les tribunaux du Canada.

Le taux d'intérêt est établi chaque trimestre par les tribunaux du Canada en vertu de la *Loi sur les tribunaux judiciaires*. Le taux d'intérêt en vigueur est égal au taux d'escompte de la Banque du Canada (arrondi au nombre entier suivant), plus un pour cent. Les taux d'intérêts sont publiés chaque trimestre dans la *Gazette de l'Ontario*. Voir également le *Bulletin des politiques*, vol. 7, n° 1.

Les taux d'intérêts en vigueur pour les deuxième et troisième trimestres de 1994 sont de 6 % et 8 % respectivement.

(Voir document 05-01-08, Versements d'intérêts.)

## Certificats de retour au

### travail

La situation se présente couramment : l'employeur demande au travailleur un certificat médical attestant qu'il est apte à retourner au travail avant de lui permettre de recommencer à travailler. Le travailleur consulte son médecin traitant, obtient le certificat demandé et retourne au travail. En pareil cas, qui doit assumer les frais engagés pour la délivrance de ce certificat? La CAT, l'Assurance-santé de l'Ontario ou l'employeur?

Etant donné que ni la *Loi* ni la CAT n'exigent que le travailleur obtienne un tel certificat, la CAT n'assume pas les frais engagés pour sa délivrance. Ces frais ne sont pas plus couverts par l'Assurance-santé de l'Ontario puisque, en vertu d'une modification apportée à la *Loi sur l'assurance-santé* de l'Ontario en décembre 1993, c'est la tierce personne qui est responsable des frais engagés pour la fourniture d'un document ou d'un renseignement, ou l'obtention d'un service non assuré. Dans le cas qui nous intéresse, le certificat de retour au travail est considéré comme un document non assuré et l'employeur est considéré comme la tierce personne devant payer pour la délivrance de ce document.

Le ministère de la Santé élabore actuellement des règlements à ce sujet; toute demande de renseignements devrait lui être adressée au (416) 314-5518 ou au 1-800-268-1154.

## Avis

Congrès triennal de l'IEA  
Toronto - 15 au 19 août 1994

Le congrès triennal de l'IEA (International Association of Ergonomics - Association internationale d'ergonomie) constitue un forum international d'échange d'information en matière d'ergonomie. Le programme de ce congrès reflète la diversité des intérêts propres à chaque secteur de l'ergonomie; ainsi, des séances spéciales, des tables rondes, des séminaires, de même que des présentations de documents techniques et d'affiches, mettront en lumière plus de mille communications provenant de partout dans le monde. Vingt-quatre conférenciers éminents, représentant divers champs de spécialisation, présenteront dans le cadre de leur allocation une vue d'ensemble de leur domaine d'expertise. Les participants pourront perfectionner leurs connaissances sur le plan professionnel au cours de divers ateliers et de diverses visites techniques; par ailleurs, un atelier particulier ayant pour thème «Introduction à l'ergonomie» facilitera l'orientation et l'intégration des nouveaux venus dans ce domaine.

Pour plus de renseignements, veuillez contacter le :

Secrétariat de l'IEA 94  
a/s de JPdL Multi Management Inc.  
Toronto Dominion Centre  
55, rue King Ouest, bureau 2550  
Toronto (Ontario) M5K 1E7  
Téléphone : (416) 784-9396

## Bulletin des politiques

Le **Bulletin des politiques** est publié par la Direction des politiques sur l'indemnisation de la Commission des accidents du travail. S'il y a contradiction entre le texte de la présente publication et la *Loi sur les accidents du travail* et/ou les politiques approuvées de la Commission, c'est à la *Loi* ou aux documents approuvés qu'il faut se référer.

Veuillez adresser vos questions ou commentaires à la :

Rédactrice  
**Bulletin des politiques**  
Publication des politiques  
Commission des accidents du travail  
2, rue Bloor Est, 22<sup>e</sup> étage  
Toronto (Ontario) M4W 3C3

## Respect de la Loi de la part des employeurs

La CAT met tout en oeuvre pour inciter les employeurs à se conformer aux obligations qui leur incombent aux termes de la Loi. Le 20 octobre 1993, le conseil d'administration a approuvé une politique et des directives faisant état des amendes que la CAT peut imposer et des mesures qu'elle doit entreprendre avant d'intenter des poursuites contre les employeurs qui négligent de se conformer à de telles obligations. Pour les infractions survenues le 1<sup>er</sup> janvier 1994 ou après cette date, la CAT intentera normalement des poursuites contre les employeurs seulement **après** que les mesures entreprises auprès de ceux-ci afin de les inciter à respecter la Loi auront été vaines. Toutefois, dans les cas où l'employeur aurait été trouvé coupable d'une infraction aux termes de la Loi au cours des cinq dernières années, la CAT pourra commencer à intenter des poursuites immédiatement.

Si un employeur ne se conforme pas aux exigences prescrites par la Loi, la CAT lui envoie des avis par courrier recommandé pendant deux mois consécutifs afin de l'informer :

- de la nature de l'infraction;
- de la date à laquelle cette infraction a été commise;
- de l'amende dont il peut être passible;
- des dispositions qu'il doit prendre afin de se conformer à la Loi;
- de la date à laquelle il doit s'être acquitté de cette obligation.

Les employeurs qui ne se sont pas acquittés de leur obligation dans les délais prescrits dans les avis peuvent être poursuivis en justice. Sur déclaration de culpabilité, ces employeurs peuvent se voir imposer une amende pouvant atteindre le montant maximal indiqué dans le tableau ci-dessous.

Paragraphe de la Loi	Description de l'infraction	Amende maximale
20 (2)	L'employeur retient sur le salaire d'un de ses travailleurs une partie d'une somme qu'il était tenu de verser au travailleur à titre d'indemnité.	10 000 \$
50 (9)	L'employeur reçoit d'un travailleur une contribution au titre des dépenses relatives aux soins médicaux engagées dans le cadre de l'indemnisation du travailleur.	10 000 \$
63 (4)	L'employeur contrevient à une règle d'une association approuvée pour promouvoir la prévention des accidents.	10 000 \$
71 (8)	L'employeur ou son représentant divulgue les renseignements médicaux se rapportant à un travailleur ou à un cas donné.	5 000 \$
109 (6)	L'employeur ne soumet pas dans les délais prescrits un état exact du montant estimatif de la liste de paye et du montant qu'il prévoit dépenser au titre des salaires.	25 000 \$
111 (3)	L'employeur ne soumet pas des registres exacts de la liste de paye aux personnes autorisées à en faire la vérification afin que celles-ci s'assurent que les salaires sont présentés correctement.	25 000 \$
113 (2)	L'employeur interdit aux personnes autorisées à cette fin de faire l'inspection de sécurité des locaux où travaillent les travailleurs.	25 000 \$
130 (3)	L'employeur ne verse pas de montant suffisant pour payer la cotisation relative à une industrie qu'il exploite et qui ne fonctionne que temporairement.	25 000 \$
133 (2)	L'employeur fait défaut de déclarer une lésion ou une maladie dans les 3 jours qui suivent le moment où il apprend la survenue de cette lésion ou l'apparition de cette maladie	25 000 \$

(Voir document 08-08-03, Poursuite contre les employeurs.)



## Perte de salaire reliée à une évaluation médicale pour perte non économique (PNE) (suite)

- Les travailleurs qui reçoivent une indemnité pour PEF sont indemnisés de leur perte de gains aux termes de l'article 74 de la Loi. Ils ne peuvent être indemnisés aux termes de l'article 37, car le paragraphe 37 (1) ne leur permet pas de toucher à la fois une indemnité pour PEF et des indemnités d'invalidité totale temporaire pour une même lésion ou maladie.

Cette politique s'applique aux travailleurs qui ont subi des évaluations pour PNE le 4 juillet 1994 ou après cette date.

(Voir document 05-06-12, Perte de salaire reliée à une évaluation pour PNE, envoi n° 31.)

## Aide à la réinstallation

En décembre 1993, le conseil d'administration a modifié la politique et les directives régissant l'aide à la réinstallation prévue dans le cas des travailleurs qui doivent déménager du fait qu'ils se sont trouvés un emploi à l'extérieur de leur localité.

Depuis le 1<sup>er</sup> mars 1994, la CAT paie les frais de réinstallation d'un travailleur si celui-ci se trouve un emploi à l'extérieur de sa localité par suite d'une recherche d'emploi menée à la demande de la CAT, ou d'une entente convenue entre le travailleur et l'agent de réadaptation professionnelle.

Pour que la CAT assume les frais de réinstallation d'un travailleur, il doit maintenir être établi que l'augmentation de gains dont le travailleur est susceptible de bénéficier à long terme, en raison de son nouvel emploi, est plus importante que ce qu'il en coûtera en frais de déménagement. De plus, il doit être établi que les frais de réinstallation sont engagés de façon responsable.

Pour que la CAT paie les frais de réinstallation, de nouveaux critères doivent être remplis :

- Le travailleur doit s'être engagé à occuper un emploi permanent qui cadre avec ses objectifs de réadaptation.
- Le nouveau lieu de travail est situé à 60 km ou plus du lieu de résidence actuel du travailleur, et le nouveau lieu de résidence est plus près du nouveau lieu de travail que ne l'est le lieu de résidence actuel, et ce par une distance de 40 km ou plus.
- Le travailleur ne bénéficie pas d'une aide financière de la part de l'employeur qui l'a engagé. Dans le cas contraire, l'aide accordée ne doit pas couvrir les frais de réinstallation. Si l'aide consentie couvre de tels frais, la CAT paie la différence entre le montant de l'aide accordée par l'employeur et les frais autorisés par la CAT.

(Voir document 07-03-12, Aide à la réinstallation.)

## Article 48 de la Loi, Saisie-arrêt

Aux termes de l'article 48 de la Loi, si un travailleur a droit à des indemnités et que son conjoint ou les personnes à sa charge ont droit à des aliments en vertu d'une ordonnance du tribunal, la Commission peut déduire de ces indemnités les sommes nécessaires pour respecter cette ordonnance. La Loi sur les salaires limite cependant ces déductions à 50 % des indemnités payables au travailleur, à moins que le tribunal n'en décide autrement.

À l'exception des fonds mis en réserve aux termes du paragraphe 44 (1) de la Loi, toute indemnité payable à un travailleur est réputée être un salaire pouvant être assujéti à une ordonnance de saisie-arrêt.

Cette politique s'applique dans le cas des ordonnances de saisie-arrêt émises après le 1<sup>er</sup> avril 1985 et dont les déductions qui en découlent se poursuivent après le 1<sup>er</sup> décembre 1991. (Voir document 05-01-16, Saisie-arrêt.)



important

Voici les points importants tirés des nouvelles politiques et des politiques révisées en application depuis juin 1993. Veuillez consulter le Manuel des politiques opérationnelles (PO) pour obtenir le texte intégral des politiques et des directives. Si vous n'avez pas de manuel et aimeriez en acheter un exemplaire, veuillez téléphoner au (416) 927-4941.

En octobre 1993, le conseil d'administration a approuvé une modification touchant le montant de l'indemnité de maintien pour PEF. Ainsi, la CAT paie une indemnité de maintien de 1,00 \$ par année dans le cas des dossiers où, au moment de la détermination initiale ou de la révision de l'indemnité pour PEF, le droit à l'indemnité pour PEF prend effet le 1<sup>er</sup> décembre 1993 ou après cette date. Auparavant, le montant de l'indemnité de maintien s'établissait à 1 % de 90 % des gains moyens nets du travailleur avant l'accident.

L'indemnité de maintien n'a pas pour but d'indemniser le travailleur de la perte de salaire qu'il subit. Elle permet plutôt à la CAT d'envisager le versement d'un supplément au travailleur [paragraphe 43 (9) de la Loi sur les accidents du travail], jusqu'au moment de la prochaine révision de l'indemnité pour PEF si :

- le travailleur participe à un programme de réadaptation professionnelle visant à lui permettre de toucher des gains comparables à ceux d'avant la lésion;
- on ne s'attend pas à ce que le travailleur soit en mesure de toucher des gains comparables ou supérieurs à ses gains d'avant la lésion.

(Voir document 05-05-05, Détermination initiale - Travaillleurs pour lesquels un plan de réadaptation professionnelle a été établi, et document 05-05-06, Travaillleurs qui gagnent un salaire au moment de la détermination.)

Si un travailleur est victime d'une lésion dont la gravité est telle que dans le cadre d'un dossier il a droit à une indemnité d'invalidité totale permanente (100 %) et qu'il décède par la suite, le survivant du travailleur a droit à la même indemnité (indemnité de décès) que celle qui lui aurait été versée si le travailleur était décédé au moment de l'accident.

Cette directive s'applique :

- dans le cas des dossiers dont la date d'accident est **antérieure** au 2 janvier 1990 et
- dans le cas où, dans le cadre de ces dossiers, des décisions sont prises au sujet des périodes d'indemnisation qui s'appliquent, et ce le 1<sup>er</sup> juillet 1993 ou après cette date.

(Voir document 05-03-10, Versements aux personnes à charge.)

Les travailleurs qui doivent s'absenter du travail afin de subir une évaluation médicale pour PNE ont droit à une indemnité pour perte de salaire. En pareil cas, le montant de l'indemnisation varie selon que le travailleur touche une indemnité pour perte économique future (PEF) ou non.

- Les travailleurs qui **ne reçoivent pas** d'indemnité pour PEF sont indemnisés de leur perte de gains aux termes de l'article 37 de la Loi.

Perte de salaire reliée à une  
évaluation médicale pour perte  
non économique (PNE)

Indemnité de décès versée  
aux survivants

Indemnité de maintien pour  
perte économique future (PEF)



# Policy Report



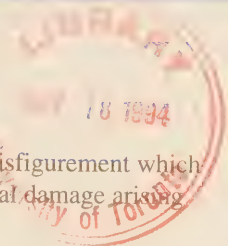
Workers'  
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## The NEL process

Sections 42 and 43 of the *Workers' Compensation Act* (the *Act*) establish a dual award system for compensating permanently impaired injured workers: NEL (non-economic loss), and FEL (future economic loss).

**FEL** compensates workers for **economic loss** that they may suffer in the future because of a work-related injury/disease—in broad terms comparing a worker's earning capacity **before** the work-related injury/disease, to the earning capacity **after** the injury/disease. (See *Policy Report* Vol.4 No.5; *Operational Policy* manual documents 05-05-04, 05-05-06, and 05-05-14.)

**NEL**, on the other hand, compensates injured workers for the expected **non-economic loss** resulting from the effects of a permanent impairment.

This issue of *Policy Report* takes a comprehensive look at the process for determining NEL permanent impairment using the American Medical Association *Guides to the Evaluation of Permanent Impairment, Third Edition—Revised* (the *AMA Guides*), and for calculating NEL benefits.

The *AMA Guides* is a reference book that sets out medical and scientific procedures for determining permanent impairment caused by a variety of injuries and diseases. Section 42(5) of the *Act* requires the WCB to determine the degree of a worker's permanent impairment "in accordance with the prescribed rating schedule." Section 15 of Regulation 1102 names the *AMA Guides, Third Edition—Revised*, as the prescribed rating schedule.

### Maximum medical rehabilitation (MMR)

The process for determining the degree of a worker's permanent impairment can be lengthy due, in part, to the timeframes imposed by the *Act*. It begins when a WCB decision-maker concludes that the worker has reached maximum medical rehabilitation (MMR). The decision-maker establishes MMR by reviewing all medical reports, including the *Physician's Progress Report Form 26*, the medical rehabilitation clinic's reports, and the chart of usual healing times (see 02-03-03). If there are any questions, the decision-maker consults the unit medical advisor.

To establish the degree of permanent "impairment," the WCB, by law, must have the worker undergo a medical examination or an assessment by a physician from the WCB's roster of physicians appointed by the Lieutenant-Governor-in-Council, i.e., the Ontario government cabinet. Section 1(1) of the *Act* describes an impairment (in relation to an injured worker) as "any physical or

functional abnormality or loss including disfigurement which results from an injury and any psychological damage arising from the abnormality or loss."

### NEL medical assessment

Once the decision-maker determines that the worker is at MMR and that there is a permanent impairment, the WCB sends the worker a list of physicians who have clinical experience in the worker's type of injury/disease and who, where possible, practice in the worker's geographic area.

From this list, the *Act* requires the worker to select a physician to conduct the medical assessment within 30<sup>1</sup> days.

Section 42(11) of the *Act* states that if a worker does not make a selection "...within thirty days after the Board provides the worker with a roster of medical practitioners, a medical practitioner appointed by the Board shall conduct the medical assessment."

Workers notify the WCB of their choice of physicians by telephone, mail, FAX, or in person.

As soon as a physician is chosen, the NEL clerk

- books an appointment with the roster physician to examine the worker
- sends the worker a letter with all the pertinent information: physician's name, address, and telephone number; appointment date, and time; and, if necessary, travel and accommodation instructions (see *Policy Report*, Vol.4 No.5).

The NEL clerk sends the roster physician

- a letter confirming the appointment
- the complete medical section of the injured worker's claim file
- a package of medical forms to be completed and returned following examination of the worker.

The medical forms the roster physician completes include a **basic** package, an **impairment-specific** package, and/or a narrative report.

1. The WCB allows an extra 5 days for mail delivery.

The basic package consists of 4 WCB-generated forms—the

- *NEL Summary Report*
- *Likely Future Consequences*
- *Soft Tissue Pain Diagram*
- *Non-Economic Loss Billing*.

The impairment-specific forms consist of the

- *Dorso-Lumbar & Pelvis Set*
- *Upper Extremity Set*
- *Lower Extremity Set*
- *Cervical Spine Set*
- *Activities for Daily Living (ADL) Analysis form*
- *Impairment Class Summary Mental Behavioural Disorders/CPD (chronic pain disability)/fibromyalgia form*
- *Visual Assessment form*.

The combination of medical forms completed depends on the nature of the worker's impairment. For example, as noted in the forms illustrated in the insert, Jenny Bélanger (the fictitious name of the worker used in this case study) suffered a right knee injury. In this example the roster physician completes the: *NEL Summary Report*; *Likely Future Consequences form*; *Soft Tissue Pain diagram*; the *Lower Extremity Recording Form*; and the *Lower Extremity Neurologic Recording Form*.

Once completed, the forms must be returned to the WCB by the roster physician within 14 days of examining the worker. The NEL adjudicator reviews the forms and, if they are in order, a NEL clerk mails a copy of the medical assessment report to the injured worker, the accident employer, and/or their authorized representatives. The worker and the employer have 45 days to review the report.

If neither of the 3 parties objects (see Objections, p. 3) to the assessment, the process moves forward to the final steps: rating the impairment and calculating the NEL benefit.

## Second NEL medical assessment

On the other hand, if the worker, the employer, or the WCB objects to the first medical assessment, the law requires a second NEL assessment. However, the request for a second assessment must be made within the 45-day review period.

When a second assessment is requested, the process begins anew. The WCB voids the first assessment, and the second becomes the official assessment for rating purposes.

But, when there is an objection by any of the parties to the first NEL medical assessment, the choice of a roster physician is no longer the worker's alone.

For the second assessment, s. 42(15) of the *Act* states:

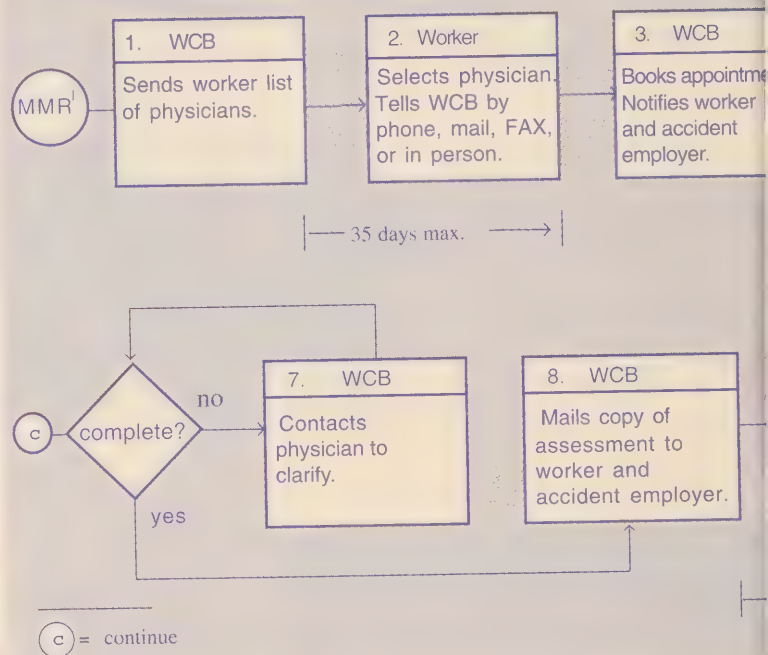
"If a second medical assessment is required, the Board shall provide the worker and the employer with a list of at least three medical practitioners

selected from a roster, from among whom the worker and the employer, by agreement within 30 days after receiving the list, may select a medical practitioner who shall conduct the medical assessment."

If, however, the worker and the employer cannot agree on a physician, the *Act* authorizes the WCB to nominate a physician from a list other than that provided to the worker and the employer.

The WCB follows the same procedures used in the first medical assessment for booking the appointment and reviewing the completeness of the report except that, in the case of a second assessment, the 45-day review period does not apply. The WCB reviews the forms and rates the impairment.

## The NEL process: Overview



## Rating the NEL impairment & calculating the NEL benefit

When determining entitlement, NEL adjudicators use a rating sheet specific to the impairment. The rating sheet is a calculation or work sheet on which NEL adjudicators note information used to calculate the percentage of permanent impairment.

## A case study (see insert for illustrations of forms and charts)

Jenny Bélanger suffered a work-related injury to her right knee. On examination of the injury, the roster physician recorded on the *Lower Extremity Recording Form* a range of motion (flexion) of



130 degrees, and an extension lag of 10 degrees. (Flexion is described as the act of bending a part of the body; extension, the act of straightening a part of the body.)

To arrive at the percentage of permanent impairment of Jenny's injury, the WCB referred to the *AMA Guides* - Table 39 (see insert) and found that

1. flexion of 130° = 7% of lower extremity impairment
2. extension of 10° = 1% of lower extremity impairment.

The *AMA Guides* directs that these 2 values (7% and 1%) be added: for a total percentage impairment of 8%. (A)

Additionally, the roster physician's report indicates a torn lateral meniscus (a disc of cartilage located in a joint between the surfaces of the articulating bones). Applying the *AMA Guides* -

- follow both lines to where the points intersect (17) for a total impairment of the lower extremity of 17%.

### Rating the injury relative to the whole person

All NEL benefits must be expressed as a percentage impairment of the whole person. In our example, the NEL adjudicator, using Table 46 (see insert) of the *AMA Guides* must convert Jenny's 17% lower extremity impairment to a whole person impairment which is 7%.

### What is the dollar value of Jenny's NEL benefit?

Jenny Bélanger was 27 years old when she reached MMR. According to the formula in s.42(2) of the Act

$$\text{NEL benefit} = \left( \frac{\text{Base amount} + \text{Age adjustment factor}}{\text{ment factor}} \right) \times \% \text{ permanent impairment}$$

the actual amount of Jenny's NEL benefit is calculated as follows:

- Take the NEL base amount of \$45,000, indexed to \$50,973.19 for 1994
- add the NEL adjustment factor of \$1,000, indexed in 1994 to \$1,132.62 for each year she is under the age of 45 (18 years), then
- multiply by the percentage of the whole person impairment: 7%.

$$[\$50,973.19 + (18 \times \$1,132.62)] \times 7\% = \$4,995.22$$

### Payment

Depending on the dollar amount of the NEL benefit, a worker is paid either in a lump sum or as a monthly pension. The law authorizes the WCB to pay benefits over \$10,000<sup>2</sup> in monthly amounts "unless the worker elects to receive the compensation as a lump sum." Amounts less than or equal to \$10,000<sup>2</sup> are paid as lump sums. The WCB also pays interest on NEL benefits, retroactive to the date MMR was reached.

Jenny's NEL benefit of \$4,995.22 (and interest) is paid in a lump sum.

### Objections

Other than the objection to the physician's NEL assessment, which must be made within the 45 day review period, workers and employers may also object to the percentage of permanent

*continued on page 4*

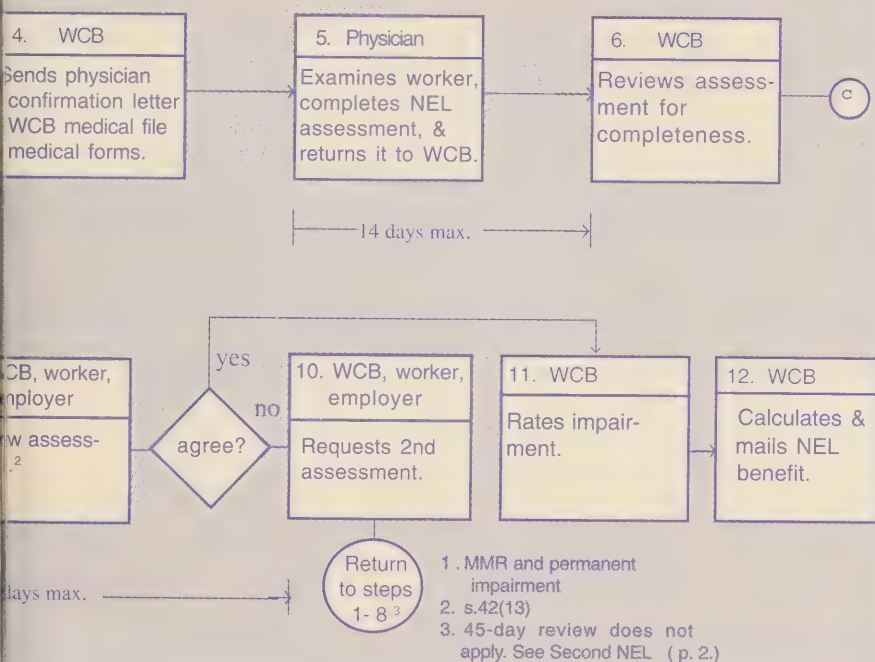


Table 40 (see insert), the value of one torn meniscus falls in a range of 0% to 10%.

Based only on the information in Jenny's NEL assessment, the NEL adjudicator determined that Jenny's impairment of the lower extremity is 10% (B), because it is a full thickness tear of a single meniscus.

To arrive at a total impairment value, the NEL adjudicator is directed by the *AMA Guides* Combined Values Chart to:

- locate the larger of the two values (B=10%) on the left side of the chart (see insert)
- locate the smaller value at the bottom of the chart (A= 8%)

2. These are 1990 dollars. All \$-amounts stated in the Act are indexed annually. For information on indexing benefits, see 05-01-02.

impairment arrived at by the WCB (see 05-06-08).

Under the guidelines, if either Jenny or her employer filed an objection, the NEL medical co-ordinator would review the evaluation of her permanent impairment, make a decision, and notify both parties of the results of the review. If the parties were dissatisfied with the results of the medical co-ordinator's review, the case would then go to a WCB hearings officer and, further, to the Workers' Compensation Appeals Tribunal, if appealed.

## Redetermination

If Jenny's injury worsened significantly over time, and it was unexpected, s.42 of the *Act* gives her the right to apply for a redetermination of her condition after 12 months have passed from the most recent decision on the degree of her permanent impairment.

*Policy Publications wishes to thank the NEL staff in CCU-I for their co-operation in the publication of this issue of Policy Report.*

## Correction

In the June 1994 issue of *Policy Report*, Vol. 7 No.4, we published an article on Hand-arm vibration syndrome (HAVS) in which we stated "The tools most commonly associated with vibration include pneumatic tools (i.e., diamond drills), pneumatic hammers...." Shortly after publication, Mr. Reynald Michaud of the Canadian Diamond Drilling Association called to tell us that diamond drills should not be confused with pneumatic drills that strike or hammer rock. Diamond drills rotate rather than strike.

In the same article, we said that NEL roster physicians take a detailed clinical and non-clinical medical history, and conduct a complete physical examination including appropriate lab tests and diagnostic procedures. In fact, NEL roster physicians do not, themselves, do the lab tests or the diagnostic procedures.

## NEL facts & figures

• Allowed lost-time claims from January 2, 1990 to July 1, 1994	= 664,311
• Lost-time claims eligible for NEL determination as of July 1, 1994	= 49,331
• NEL claims decided as of July 1, 1994	= 38,954
• Average number of NEL claims in process as of July 1, 1994	= 16,000
• Average time-lag from an MMR decision to a NEL decision	= 10 months
• Average age of worker at time of accident	= 43 years
• Average permanent impairment per NEL benefit	= 12%

WCB Corporate Data - August, 1994

## Policy Report

**Policy Report** is published under the authority and direction of the Benefits Policy Branch of the Workers' Compensation Board. If there is any conflict between the statements contained in this publication and the Workers' Compensation *Act* and/or Board-approved policy documents, the *Act* or the approved document governs.

Comments or inquiries should be addressed to:  
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L'indemnité est supérieure à 10 000,00 \$?, «à moins que celui-ci ne choisisse de recevoir une somme forfaitaire». Toute indemnité pour PNE qui est inférieure ou égale à 10 000,00 \$ est versée sous forme de somme forfaitaire. De plus, la CAT paye des intérêts sur l'indemnité pour PNE rétroactifs à la date à laquelle le travailleur a atteint sa RMM.

Dans le cas de Jenny Bélanger, l'indemnité pour PNE de 4 995,22 \$ et les intérêts ont été versés en un seul paiement.

### Contestations

Outre le droit de contester l'évaluation pour PNE effectuée par le médecin, et ce dans le délai prescrit de 45 jours, le travailleur et l'employeur peuvent contester le pourcentage de déficience permanente établi par la CAT. (Voir le document 05-06-08.) Conformément aux directives à ce sujet, si Jenny ou son employeur contestait la décision rendue par la CAT, un coordonnateur médical pour PNE passerait en revue l'évaluation portant sur la déficience permanente de la travailleur, rendrait une décision et aviserait les deux parties des résultats de l'étude effectuée. Si l'une ou l'autre des parties était toujours insatisfaite de la décision rendue par le coordonnateur médical pour PNE, le cas serait alors transmis à un commissaire d'audience de la CAT et, par suite d'un autre appel, déposé devant le Tribunal d'appel des accidents du travail.

### Nouvelle détermination

Si la lésion de Jenny se détériore de façon significative et imprévue, l'article 42 de la Loi prévoit que la travailleur peut demander à la CAT de réévaluer sa déficience après que douze mois se sont écoulés depuis la décision la plus récente concernant le degré de déficience permanente initialement accordé.

Il s'agit de dollars de 1990. Tous le montants exprimés en dollars dans la Loi sont indexés annuellement. Pour obtenir des renseignements sur l'indexation des indemnités, voir le document 05-01-02.

### Correction

Dans l'édition de juin 1994 du *Bulletin des politiques*, vol. 7, n° 4, un article portant sur le syndrome vibratoire précisait ce qui suit : «Parmi les outils les plus souvent associés aux vibrations, mentionnons : les outils pneumatiques (p. ex., les perforatrices à diamants); les marqueurs pneumatiques (...).» Peu de temps après la publication de ce numéro, M. Reynald Michaud de la Canadian Diamond Drilling Association nous a téléphoné pour nous informer qu'il ne faut pas confondre les perforatrices à diamants, qui font un mouvement de rotation, avec les perforatrices pneumatiques, qui font un mouvement de frappe.

### Faits et chiffres relatifs à la PNE

- Demandes d'indemnisation avec interruption de travail acceptées du 2 janvier 1990 au 1<sup>er</sup> juillet 1994 = 664 311
- Demandes d'indemnisation pour PNE à une détermination pour PNE à compter du 1<sup>er</sup> juillet 1994 = 49 331
- Demandes d'indemnisation pour PNE ayant fait l'objet d'une décision le 1<sup>er</sup> juillet 1994 = 38 954
- Nombre moyen des demandes d'indemnisation pour PNE à l'étude le 1<sup>er</sup> juillet 1994 = 16 000
- Délai moyen entre la décision relative à la RMM et celle relative à la PNE = 10 mois
- Âge moyen du travailleur au moment de l'accident = 43 ans
- Pourcentage moyen de déficience permanente par indemnité pour PNE = 12 %

Données administratives de la CAT  
Août 1994

La Section de la publication des politiques désire remercier le personnel chargé de la PNE à l'Unité des dossiers complexes (l'élions) de sa collaboration au présent numéro du Bulletin des politiques.

### Bulletin des politiques

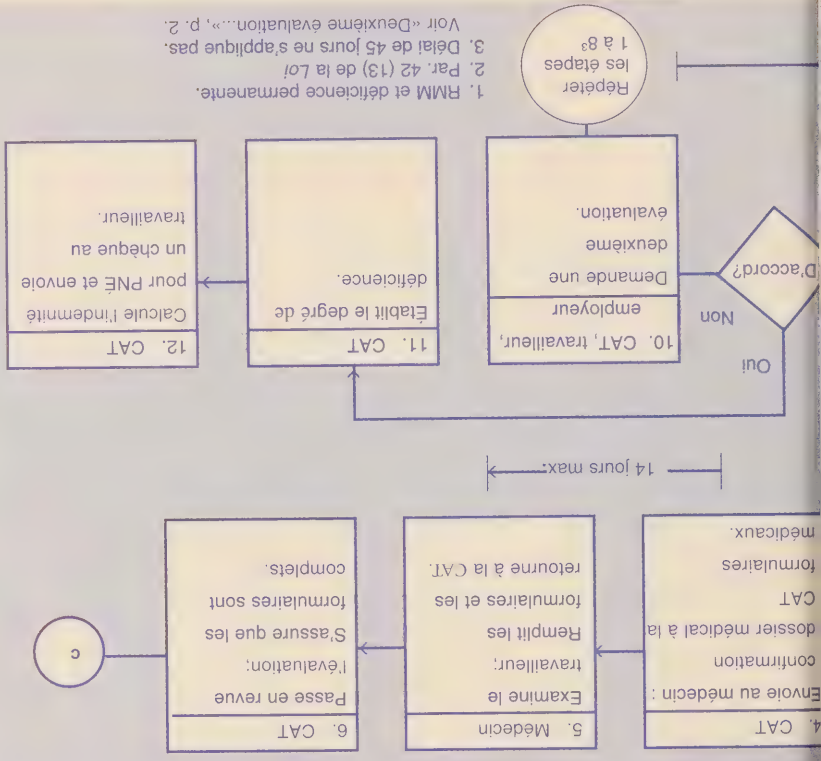
Le *Bulletin des politiques* est publié par la Direction des politiques sur l'indemnisation de la Commission des accidents du travail. S'il y a contradiction entre le texte de la présente publication et la Loi sur les accidents du travail et/ou les politiques approuvées de la Commission, c'est à la Loi ou aux documents approuvés qu'il faut se référer.

Veuillez adresser vos questions ou commentaires à la :  
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**Bulletin des politiques**  
Publication des politiques  
Commission des accidents du travail  
22<sup>e</sup> étage  
2, rue Bloor est  
Toronto (Ontario) M4W 3C3

## Détermination du degré de déficience et calcul de l'indemnité pour PNE

Pour déterminer si le travailleur a droit à une indemnité pour PNE, l'agent d'indemnisation pour PNE utilise une fiche d'évaluation se rapportant précisément à la déficience dont le travailleur est atteint. Cette fiche est en fait une feuille de calcul ou de travail sur laquelle l'agent d'indemnisation pour PNE inscrit des renseignements servant au calcul du pourcentage de déficience permanente.

**Étude de cas** (Voir les formulaires et tableaux sur l'encart.)  
Jenny Bélanger a subi une lésion professionnelle au genou droit. À l'examen, le médecin du tableau a inscrit sur le *Formulaire d'enregistrement des données - Membres inférieurs* que, en ce qui a



trait à l'amplitude des mouvements, la travailleuse avait une flexion de 130 degrés et un retard d'extension de 10 degrés. Pour obtenir le pourcentage de déficience permanente attribué à la lésion de Jenny, la CAT s'est reportée au Tableau 39 (voir encart) des guides de l'AMA, et a établi ce qui suit :  
Flexion de 130° = 7 % de déficience du membre inférieur.  
Extension de 10° = 1 % de déficience du membre inférieur.  
Les guides de l'AMA précisent que ces deux valeurs, soit 7 % et 1 %, doivent être additionnées, ce qui donne un pourcentage total de déficience de 8 % (valeur A).  
Le rapport du médecin du tableau faisait également état d'une déchirure du ménisque externe (disque cartilagineux situé entre les deux surfaces articulaires du genou). Selon le Tableau 40 (voir

- suivre la ligne et la colonne ainsi repérées jusqu'à leur point d'intersection, soit 17; la valeur totale de la déficience du membre inférieur est de 17 %.

### Effet de la déficience permanente sur la personne globale

Toute indemnité pour PNE doit être exprimée en tant que pourcentage de déficience par rapport à la personne globale. Dans notre étude de cas, l'agent d'indemnisation pour PNE a consulté le Tableau 46 (voir encart) des guides de l'AMA pour convertir le pourcentage de déficience du membre inférieur de 17 % en pourcentage de déficience sur la personne globale qui est de 7 %.

**Quelle est le montant de l'indemnité de Jenny ?**  
Jenny Bélanger était âgée de 27 ans lorsqu'elle a atteint sa RMM. Selon la formule énoncée au paragraphe 42 (2) de la Loi,

$$\text{Indemnité pour PNE} = \left( \begin{array}{l} \text{Montant de base} \\ + \text{ajustement selon l'âge} \end{array} \right) \times \begin{array}{l} \% \text{ de déficience} \\ \times \text{ déficience permanente} \end{array}$$

- prendre le montant de base de 45 000, 00 \$, indexé à 50 973,19 \$ en 1994;
- ajouter le facteur de rajustement de 1 000,00 \$, indexé à 1 132,62 \$ en 1994, pour chaque année que la travailleuse a de moins de 45 ans (18 ans);
- puis multiplier le tout par le pourcentage de déficience sur la personne globale qui est de 7 %.

$$[50\,973,19 \$ + (18 \times 1\,132,62 \$)] \times 7 \% = 4\,995,22 \$$$

### Paiement de l'indemnité pour PNE

Selon le montant de l'indemnité pour PNE, le travailleur reçoit un paiement forfaitaire ou une pension mensuelle. La Loi autorise la CAT à effectuer des versements mensuels au travailleur si



- une série de formulaires médicaux que le médecin doit remplir et retourner après avoir examiné le travailleur.
- Les formulaires médicaux que remplit le médecin du tableau consistent en une série de formulaires de base, une série de formulaires portant sur la déficience et un rapport narratif.
- La série de formulaires de base comprend les quatre formulaires suivants :
- Sommaire - Perte non économique
- Conséquences futures probables - Pronostic
- Diagramme - Douleurs aux tissus mous
- Facturation - Perte non économique

La série de formulaires portant sur la déficience est répartie comme suit :

- Région dorso-lombaire et pelvienne
- Membres supérieurs
- Membres inférieurs
- Région cervicale

- Analyse des activités de la vie quotidienne
- Sommaire de catégorie de déficience
- Troubles du comportement et troubles mentaux, IDC (invalidité attribuable à la douleur chronique) et fibromyalgie

- Evaluation de la vision.

La série de formulaires médicaux devant être remplie est établie en fonction de la nature de la déficience du travailleur. Par exemple,

comme il est indiqué dans les formulaires illustrés sur l'encart, Jenny Bélanger (nom fictif de la travailleuse qui fait partie de l'étude de cas présentée) a subi une lésion au genou droit. Ainsi, le médecin du tableau remplit les formulaires suivants : Sommaire - Perte non économique; Conséquences futures probables - Pronostic; Diagramme - Douleurs aux tissus mous; Formulaire d'enregistrement des données - Membres inférieurs; et Formulaire d'enregistrement des données - Déficience neurologique, membres inférieurs.

Une fois qu'il a rempli les formulaires, le médecin du tableau doit les retourner à la CAT dans les 14 jours qui suivent l'examen du travailleur. L'agent d'indemnisation pour PNE passe ensuite en revue les formulaires et, s'ils sont en règle, un préposé à la PNE fait parvenir une copie du rapport d'évaluation médicale au travailleur blessé, à l'employeur au moment de l'accident et/ou aux représentants autorisés de ces derniers. Le travailleur et l'employeur ont 45 jours pour étudier le rapport. Si aucune des parties ne conteste les résultats de l'évaluation, (voir «Contestations», page 4) le processus se poursuit, et les étapes finales sont ensuite mises à exécution, soit la détermination du degré de déficience et le calcul de l'indemnité pour PNE.

## Deuxième évaluation médicale pour PNE

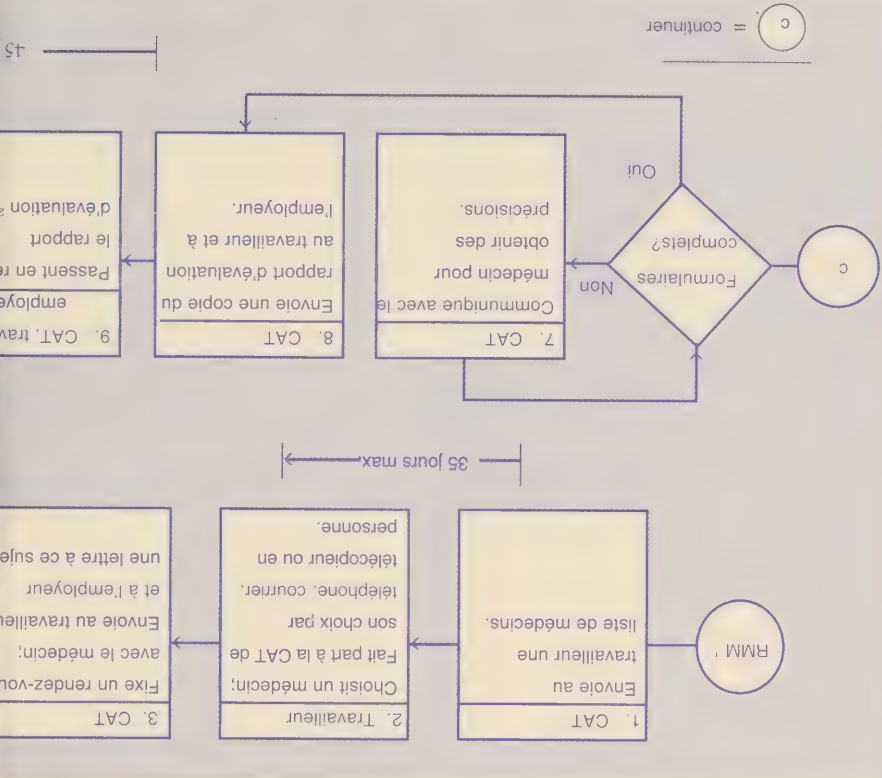
Si le travailleur, l'employeur ou la CAT conteste les résultats de la première évaluation, la Loi exige la tenue d'une deuxième évaluation pour PNE. Toutefois, la demande en vue d'une telle

évaluation doit être présentée dans le délai de 45 jours. Lorsqu'une deuxième évaluation est exigée, le processus relatif à la PNE est de nouveau entamé. La CAT ne tient pas compte de la première évaluation, et les résultats de la deuxième servent alors à établir le degré de déficience du travailleur.

Si l'une des parties en cause conteste la première évaluation médicale, le choix d'un médecin du tableau ne repose plus uniquement sur le travailleur.

Le paragraphe 42 (15) de la Loi précise ce qui suit relativement à la deuxième évaluation :

«Si une deuxième évaluation médicale est exigée, la Commission fournit au travailleur et à l'employeur, d'un d'un tableau. Le travailleur et l'employeur, d'un



commun accord et dans les trente jours qui suivent la réception de la liste, peuvent y choisir le médecin qui procède à l'évaluation médicale.»

Toutefois, si le travailleur et l'employeur ne peuvent s'entendre sur le choix d'un médecin, la Loi autorise la CAT à nommer un médecin à partir d'une autre liste que celle fournie au travailleur et à l'employeur.

La CAT entend le même processus que celui entamé lors de la première évaluation médicale pour ce qui est de prendre rendez-vous avec le médecin et d'étudier le rapport d'évaluation afin de s'assurer qu'il contient les renseignements nécessaires. Toutefois, dans le cas d'une deuxième évaluation, le délai de 45 jours ne s'applique pas. La CAT étudie les formulaires et établit le degré de déficience.



## Le processus relatif à la PNE

En vertu des articles 42 et 43 de la Loi sur les accidents du travail (la Loi), la Commission dispose d'un système d'indemnisation double visant à indemniser les travailleurs blessés qui sont atteints d'une déficience permanente : ce système comporte une indemnité pour perte économique (PBF) et une indemnité pour perte non économique (PNE).

L'indemnité pour PBF indemnise les travailleurs de la perte économique qu'ils pourraient subir dans l'avenir en raison de leur lésion ou maladie professionnelle. Cette indemnité est établie en comparant la capacité de gain du travailleur avant la lésion ou la maladie à sa capacité de gain après la lésion ou la maladie. (Voir le Bulletin des politiques, vol. 4, n° 5, et les documents 05-05-04, 05-05-06, 05-05-14 du Manuel des politiques opérationnelles.)

L'indemnité pour PNE indemnise

les travailleurs blessés de la perte économique prévue qu'ils ont subie par suite des conséquences de leur déficience permanente. Le présent numéro du Bulletin des politiques examine de plus près le processus servant à déterminer le degré de déficience permanente, au moyen du document de l'American Medical Association (AMA) intitulé *Guides to the Evaluation of Permanent Impairment*, 3<sup>e</sup> édition révisée (ci-après appelé les guides de l'AMA), et à calculer l'indemnité pour PNE.

### Réadaptation médicale maximum (RMM)

La détermination du degré de déficience permanente d'un travailleur peut être un processus de longue haleine, en partie en raison des délais prescrits par la Loi. Ce processus est enclenché lorsqu'un décideur de la CAT conclut que le travailleur a atteint sa RMM. Pour établir qu'il en est ainsi, le décideur passe en revue tous les rapports médicaux, y compris le formulaire 26 Rapport d'évolution (médécin), le rapport émis par la clinique de réadaptation médicale et le tableau des périodes de guérison normales (voir le document 02-03-03).

Si le décideur a des questions, il consulte alors le médecin-conseil. Pour établir le degré de «déficience» permanente d'un travailleur, la CAT est tenue, en vertu de la Loi, de faire subir à celui-ci un examen médical ou une évaluation auprès d'un médecin dont le nom

*Guides to the Evaluation of Permanent Impairment* est un ouvrage de référence dans lequel sont énoncés les actes médicaux et les méthodes scientifiques servant à la détermination du degré de déficience permanente associé à diverses lésions et maladies. Aux termes du paragraphe 42 (5) de la Loi, la CAT est tenue d'établir le degré de déficience permanente dont est atteint un travailleur «(...) en conformité avec le barème de taux prescrit». L'article 15 du Règlement 1102 précise que la troisième édition révisée du manuel *Guides to the Evaluation of Permanent Impairment* de l'AMA constitue le barème de taux prescrit.

### Évaluation médicale pour PNE

Dès que le décideur de la CAT établit que le travailleur a atteint sa RMM et qu'il a une déficience permanente, la CAT fait parvenir au travailleur une liste de médecins qui ont une expérience clinique dans le traitement du genre de lésion ou de maladie qu'il a, et dont le cabinet est situé, si possible, dans la région géographique où il habite. La Loi exige que le travailleur choisisse, à partir de cette liste, un médecin qui procédera à son évaluation médicale dans les 30 jours. Le paragraphe 42 (11) de la Loi précise que si le travailleur n'exerce pas son choix «dans les trente jours qui suivent le moment où la Commission lui fournit le tableau des médecins, un médecin nommé par la Commission procède à l'évaluation médicale».

Le travailleur avise la CAT de son choix par téléphone, par lettre, par télécopieur ou en personne. Dès qu'un médecin a été choisi, le préposé à la PNE :

- prend un rendez-vous avec le médecin du tableau pour que celui-ci examine le travailleur;
  - envoie au travailleur une lettre faisant état de tous les renseignements pertinents, tels que le nom, l'adresse et le numéro de téléphone du médecin; la date et l'heure du rendez-vous; et, s'il y a lieu, les dispositions relatives au déplacement et à l'hébergement. (Voir le Bulletin des politiques, vol. 4, n° 5.)
- Le préposé à la PNE fait parvenir au médecin du tableau :
- une lettre confirmant la date du rendez-vous;
  - tous les documents médicaux figurant au dossier d'indemnisation du travailleur blessé;

La CAT accorde cinq jours supplémentaires pour la livraison postale.



# Policy Report



Workers' Compensation Board

Commission des accidents du travail

December 1994

Vol. 7 No. 7

## Interjurisdictional agreement helps workers and employers



The Workers' Compensation Board of Ontario has signed an agreement that provides more common ground among workers' compensation boards (WCBs) across Canada, to the benefit of both employers and workers.

Called the Interjurisdictional Agreement on Workers' Compensation (IJA), it combines two previous agreements. The first agreement, ratified in 1979, was The Interjurisdictional Agreement for the Avoidance of Duplicate Assessments. Its purpose was to avoid double assessment of employers who have workers employed in more than one jurisdiction. The second agreement, which was approved in principle in 1983, carried the same name as the current agreement. It dealt with mutual aid and co-operation in providing services and benefits to workers when more than one jurisdiction is involved in a claim. The 1979 and 1983 agreements were combined to correct inconsistencies and to ensure conformity of administrative practices, but there were also some things added to the new agreement that weren't in the old ones, including

- a statement of principles
- a formalized dispute resolution mechanism for dealing with interjurisdictional matters that are not promptly resolved
- a standard election form to indicate the jurisdiction in which the worker is claiming compensation, and
- cost reimbursement guidelines to ensure that the WCB in the jurisdiction where the injury or fatality occurs bears the cost of the claim.

The stated intent of the new IJA is to

- avoid the duplicate payment of employer assessments for the same work
- help workers or dependants when more than one WCB may be involved in a claim
- create a system to permit any WCB to provide service to another WCB's claimants
- provide a system of dispute resolution between WCBs.

The agreement consists of

### Part I: Statement of Principles, Definitions, and Application

Part I includes details of the intent and purposes of the agreement, such as ensuring the effective, efficient, and timely administration and resolution of interjurisdictional issues. It also contains definitions of some of the language in the document, and specifies who the agreement does and does not apply to.

### Part II: Election, Cash Benefits, Benefits in Kind, Occupational Diseases, and Aggravation or Worsening of a Disability

Part II provides policy information related to the handling of claims that involve more than one jurisdiction.

### Part III: Assessments

Part III outlines how employer assessments are handled in interjurisdictional situations, and includes formulae for calculating assessments.

### Part IV: Administrative Services, Provision of Reports and Documents, and Appeals

Part IV deals with administrative matters, i.e., not charging administration costs when handling claims or assessment matters for WCBs in other jurisdictions, and exchanging necessary reports and documents for claim administration/employer auditing and assessment.

### Part V: Dispute Resolution

Part V deals with the process of mediation in the event a dispute arises between jurisdictions.

### Part VI: Effect of the Agreement

Part VI includes general provisions affecting the WCBs, such as an agreement between the WCBs to meet when necessary, and the responsibility of each WCB to make representations to their respective legislatures to amend their statutory authorities to conform with the agreement, etc.

The appendices include

#### A: Extent of Participation by Signatory Boards

This appendix contains the limitations that some jurisdictions have placed on their participation in the agreement.

#### B: Election Form

A sample of the election form that must be completed when making an interjurisdictional claim is illustrated. (To be updated in *Operational Policy* manual document 02-03-07.)

#### C: Reimbursement Guidelines

This appendix provides the details of cost reimbursement between WCBs.

# Interprovincial trucking agreement

## Reduces paperwork for truckers and trucking companies

If you're one of the "Knights of the road" and drive your rig in more than one province, or if you employ any of these drivers, we have some good news for you for 1995. Workers' compensation boards (WCBs) in Canada are working toward an agreement that will simplify the payment of your assessments.

Right now, if you're an employer of truck drivers, you are pro-rating your annual assessment for each driver between the provinces in or through which the trucker drives. In 1995, however, you may be able to pay your annual assessment for a driver to one province only, even though the driver is operating in other provinces.

Similarly, if you're an independent operator with compensation coverage you will be able to pay all assessments for a calendar year to one WCB.

The Canadian Trucking Association (CTA) contacted the Association of Workers' Compensation Boards of Canada (AWCBC) with an idea to streamline the payment of assessments made by interprovincial trucking companies and independent operators. Although some modifications must be made to accommodate the differences between the provinces in areas such as benefit entitlement and earnings ceilings, there is agreement on the general principle. A 3-year trial period begins January 1, 1995.

### Who qualifies?

To qualify for the new assessment plan in Ontario, the driver must have a strong connection with this province, which means that the driver (whether employed by a trucking company, or working as an independent operator) must

- live in Ontario and work both in and outside of the province or
- usually work in Ontario, for an employer whose place of business is in Ontario.

Examples of those who have little connection with Ontario, and therefore **do not** qualify to participate in the new assessment program include

- Ontario residents who do not work (drive) in Ontario
- non-residents of Ontario whose usual place of employment is outside Ontario
- non-residents of Ontario whose employer's place of business is outside Ontario
- independent operators who have not taken out personal coverage with the Ontario WCB.

For these drivers, assessments are paid just as they have been in the past.

If employers find that they do not qualify for the new procedure in Ontario, they can check with the other WCBs with which they deal to see if they can qualify in another province.

### Registering under the new procedure

In Ontario, independent operators with personal coverage are **automatically** included in the new procedure.

Trucking companies, however, must **apply** to the WCB using form 2642A, the "Application for Alternative Assessment Procedure for Interjurisdictional Trucking" (illustrated on page 3) which is available from your nearest Ontario WCB area or regional office. The form is designed to be user friendly, with an area for identifying information (your name, address, etc.), an area to check off which province you will pay your assessment to, and one to check off which provinces you drive through.

Trucking companies will still be registered in the other provinces through which they drive, but the assessing WCB handles the paperwork.

The new procedure covers the payment of assessments for the full calendar year, but you can still pay your assessment according to your usual payment schedule (i.e., monthly, quarterly, etc.). New applications must be received by the Ontario WCB before January 1, 1995. Once involved, you cannot opt out during a calendar year, but you may withdraw for the upcoming calendar year by providing written notice **before** the end of October in the current year.

### Making a claim

This new procedure doesn't change the process for making an out-of-province claim for workers whose usual place of employment is in Ontario. Workers still have the right to elect to claim compensation from either the Ontario WCB, or the WCB in the province in which the accident occurs (the "accident" WCB). If a worker elects to make a claim with the accident WCB, the Ontario WCB will reimburse the accident WCB for the costs of the claim.

### More information

For more information about the new procedure, contact the Ontario WCB in Toronto at (416) 927-3906 or in Thunder Bay at (807) 343-1742, or call the Ontario Trucking Association at (416) 249-7401.



Policy Report is printed on acid-free recycled paper at no extra cost.





**Workers'  
Compensation  
Board**

**Commission  
des accidents  
du travail**

# Application for Alternative Assessment Procedure for Interjurisdictional Trucking

Account Number  
9999999

Legal Name Interprovincial Trucking Limited	Trade/Company Name Interprovincial Truck Lines	
Street 181 Churchill Drive	City/Province Toronto, Ontario	Postal Code M4W 3C7
Contact Person Richard Draper	Telephone Number (416) 926-1234	FAX Number (416) 926-5678

**Authority Holder and/or Principal (specify if more than one):**

Interprovincial Trucking Limited

**Please check the boxes that apply to your operations and enter the account number:**

Province/Territory	Truckers/Workers Travelling In/Through	Truckers/Workers Resident In	Employer Account Number
Alberta	<input checked="" type="checkbox"/>	<input type="checkbox"/>	999999
British Columbia	<input checked="" type="checkbox"/>	<input type="checkbox"/>	999999-141
Manitoba	<input checked="" type="checkbox"/>	<input type="checkbox"/>	1999999
New Brunswick	<input type="checkbox"/>	<input type="checkbox"/>	
Newfoundland	<input type="checkbox"/>	<input type="checkbox"/>	
Northwest Territories	<input type="checkbox"/>	<input type="checkbox"/>	
Nova Scotia	<input type="checkbox"/>	<input type="checkbox"/>	
Ontario	<input type="checkbox"/>	<input checked="" type="checkbox"/>	9999999
Prince Edward Island	<input type="checkbox"/>	<input type="checkbox"/>	
Quebec	<input type="checkbox"/>	<input type="checkbox"/>	
Saskatchewan*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	439999-1
Yukon	<input type="checkbox"/>	<input type="checkbox"/>	

\*Saskatchewan WCB is not party to this agreement and existing reporting requirements apply.

## Terms and Conditions

1. This procedure only applies to interjurisdictional trucking.
2. The assessing WCB will notify the registering WCBs on behalf of the applicant. Additional information will be provided to the registering WCBs upon request.
3. The election to claim benefits from the jurisdiction of residence or the jurisdiction of injury remains unchanged by this procedure.
4. The applicant may not opt out of the procedure part way through a calendar year. However, they may opt out for the following year by providing two months written notice (by October 31st).
5. This procedure is adopted for a three-year trial period beginning January 1, 1995.

**I /We apply to pay assessments under the Interjurisdictional Agreement - Alternative Assessment Procedure for Interjurisdictional Trucking to the Workers' Compensation Board of**

**Ontario**

**I/We agree to abide with the provisions in the Alternative Assessment Procedure for the Interjurisdictional Trucking Industry.**

Authorized Signature <i>Richard Draper</i>	Position President	Date December 1, 1994 (See over)
---	-----------------------	--

2642A (10/94)

## Interjurisdictional agreement...

continued from page 1

### D: List of Co-ordinators

This appendix provides a list of names and phone numbers of IJA contacts at all WCBs.

### E: Alternative Assessment Procedure for the Interjurisdictional Trucking Industry

See accompanying article on page 2.

In this issue of *Policy Report* we take a look at Appendix E and how it affects the trucking industry. Watch for future issues containing information about other aspects of the agreement.

## Consultation invited

The Industrial Disease Standards Panel (IDSP) recently submitted a report (Number 13) to the Ontario WCB entitled "Report to the Workers' Compensation Board on Cardiovascular Disease and Cancer Among Firefighters," dated September 1994.

The report was published in *The Ontario Gazette* on October 1, 1994, and the deadline for submissions on this report is January 30, 1995.

Reports are available from:

Industrial Disease Standards Panel  
69 Yonge Street, Suite 1004  
Toronto, Ontario M5E 1K3  
Tel: (416) 327-4156

If you would like to provide the WCB with comments, briefs, or submissions, send them to:

Ms. Linda Angove  
Secretary to the Board  
Workers' Compensation Board  
2 Bloor Street East  
Toronto, Ontario M4W 3C3

## City of Ottawa - Corporate Health and Safety Policy Manual

The City of Ottawa reports that three years of co-operative effort between the Corporation of the City of Ottawa, its staff associations, and unions has resulted in the publication of the *Corporate Health and Safety Policy Manual*. Containing over 200 pages of policies and guidelines, this bilingual manual is designed to meet the health and safety needs of Ontario municipalities. Topics include:

- Critical injury reporting and investigation
- WCB claims management
- Workers' Compensation return to work, and
- Back injury prevention.

For more information about the manual, send a FAX to Robin Bower, manager of Corporate Health and Safety at (613) 564-1630, or write

Corporation of the City of Ottawa  
Manager, Corporate Health and Safety  
111 Sussex Drive  
Bytown Pavilion, Terrace Level  
Ottawa, Ontario  
K1N 5A1.

## Policy Report

Workers' Compensation Board  
Commission des accidents du travail

**Policy Report** is published under the authority and direction of the Benefits Policy Branch of the Workers' Compensation Board. If there is any conflict between the statements contained in this publication and the *Workers' Compensation Act* and/or Board-approved policy documents, the *Act* or the approved document governs.

### Comments or inquiries should be addressed to:

Editor  
**Policy Report**  
Benefits Policy Branch  
Workers' Compensation Board  
2 Bloor Street East, 22nd Floor  
Toronto, Ontario M4W 3C3



# Guide de la politique municipale en matière de santé et sécurité -

## Ville d'Ottawa

La Ville d'Ottawa déclare que la publication du *Guide de la politique municipale en matière de santé et sécurité* a été rendue possible grâce à l'effort concerté de La Ville d'Ottawa, de ses associations du personnel et des syndicats. Cet ouvrage bilingue de plus de 200 pages de politiques et directives a été conçu en vue de répondre aux besoins des municipalités de l'Ontario en matière de santé et sécurité.

L'ouvrage traite des sujets suivants :

- Enquêtes et rapports sur les blessures graves;
- Gestion des réclamations à la CAT de l'Ontario;
- Retour au travail des accidentés du travail;
- Prévention des blessures au dos.

Si vous désirez obtenir plus de renseignements sur ce guide, télécopiez à Robin Bower, administratrice, Santé et sécurité, au (613) 564-1630, ou écrivez à l'adresse suivante :

Robin Bower  
Administratrice, Santé et sécurité  
La Ville d'Ottawa  
111, promenade Sussex  
Pavillon Bytown, niveau Terrasse  
Ottawa ON K1N 5A1

## Consultation

Le Comité des normes en matière de maladies professionnelles (CNMP) a récemment présenté à la CAT de l'Ontario un rapport (N° 13) intitulé *Report to the Workers' Compensation Board on Cardiovascular Disease and Cancer Among Firefighters*, daté de septembre 1994.

Le rapport a été publié dans la *Gazette de l'Ontario* le 1<sup>er</sup> octobre 1994, et les observations portant sur ce rapport

doivent parvenir à la CAT au plus tard le 30 janvier 1995.

Vous pouvez obtenir une copie du rapport en communiquant avec le :

Comité des normes en matière de maladies professionnelles  
69, rue Yonge, bureau 1004  
Toronto ON M5E 1K3  
Tél.: (416) 327-4156

Si vous désirez présenter des observations ou des mémoires, veuillez les faire parvenir à :

M<sup>me</sup> Linda Angove  
Secrétaire du conseil  
Commission des accidents du travail  
2, rue Bloor Est  
Toronto ON M4W 3C3

## L'entente interprovinciale...

(suite de la page 1)

L'entente comprend également cinq annexes :

**Annexe A : Étendue de la participation des commissions**

**signataires de la présente entente**

L'annexe A expose les conditions que certains territoires ont posées relativement à leur participation à l'entente.

**Annexe B : Choix du territoire où la demande de prestation sera déposée**

L'annexe B présente le formulaire type à remplir lorsqu'une demande d'indemnisation est présentée dans le cadre de l'entente interprovinciale.

**Annexe C : Lignes directrices pour fins de remboursement**  
L'annexe C explique en détail le mode de remboursement entre les commissions.

**Annexe D : Liste des coordonnateurs**

L'annexe D fournit une liste des personnes à contacter auprès de chaque commission participante à l'entente ainsi que leur numéro de téléphone.

**Annexe E : Structure de cotisation parallèle pour l'industrie du**

**camionnage interprovincial**

Vous trouverez des renseignements sur le contenu de cette annexe dans l'article intitulé «Entente relative au camionnage interprovincial», à la page 2.

Le présent numéro du *Bulletin des politiques* traite

particulièrement de l'annexe E, qui expose la portée de l'entente sur l'industrie du camionnage. Des renseignements sur d'autres aspects de l'entente paraîtront dans les prochains numéros.

## Entente relative...

(suite de la page 2)

**Pour obtenir plus de renseignements**

Si vous désirez obtenir plus de renseignements sur la nouvelle structure de cotisation, veuillez communiquer avec le bureau central de la CAT de l'Ontario à Toronto, au (416) 927-3906, avec le bureau régional de Thunder Bay, au (807) 343-1742, ou avec l'Ontario Trucking Association, au (416) 249-7401.



Le *Bulletin des politiques* est publié par la Direction des politiques sur

l'indemnisation de la Commission des accidents du travail. S'il y a contradiction entre le texte de la présente publication et la Loi sur les accidents du travail et/ou les politiques approuvées de la Commission, c'est à la Loi ou aux documents approuvés qu'il faut se référer.

Veuillez adresser vos questions ou commentaires à la :

Rédactrice  
**Bulletin des politiques**  
Publication des politiques  
Commission des accidents du travail  
22<sup>e</sup> étage  
2, rue Bloor est  
Toronto (Ontario) M4W 3C3



Workers' Compensation Board  
Commission des accidents  
du travail

Ontario

Demande d'adhésion à la structure de cotisation  
parallèle pour l'industrie du camionnage interprovincial

N° de compte

99999999

Raison sociale	Camionnage interprovincial Ltée
Rue	181, promenade Churchill
Personne-ressource	Richard Draper
N° de téléphone	(416) 926-1234
N° de télécopieur	(416) 926-5678
Ville/Province	Toronto (Ontario)
Code postal	M4W 3G7
Nom commercial	Lignes de camionnage interprovincial
Agent autorisé et/ou entrepreneur principal (S'il y en a plus d'un, précisez le nom de chacun d'entre eux.)	Camionnage interprovincial Ltée

Veuillez cocher les cases qui s'appliquent à vos activités et inscrire le numéro de compte :

Province/Territoire	Province ou territoire dans lequel(s) quel(s) se déplacent les camionneurs/travailleurs	Province ou territoire de résidence des camionneurs/travailleurs	Numéro de compte de l'employeur
Alberta	<input checked="" type="checkbox"/>	<input type="checkbox"/>	999999
Colombie-Britannique	<input checked="" type="checkbox"/>	<input type="checkbox"/>	999999-141
Manitoba	<input checked="" type="checkbox"/>	<input type="checkbox"/>	1999999
Nouveau-Brunswick	<input type="checkbox"/>	<input type="checkbox"/>	
Terre-Neuve	<input type="checkbox"/>	<input type="checkbox"/>	
Territoires du Nord-Ouest	<input type="checkbox"/>	<input type="checkbox"/>	
Nouvelle-Écosse	<input type="checkbox"/>	<input type="checkbox"/>	
Ontario	<input type="checkbox"/>	<input checked="" type="checkbox"/>	9999999
Ile-du-Prince-Édouard	<input type="checkbox"/>	<input type="checkbox"/>	
Québec	<input type="checkbox"/>	<input type="checkbox"/>	
Saskatchewan	<input checked="" type="checkbox"/>	<input type="checkbox"/>	439999-1
Yukon	<input type="checkbox"/>	<input type="checkbox"/>	

\* La Commission des accidents du travail de la Saskatchewan ne fait pas partie de l'entente, et les exigences en matière de déclaration actuellement en vigueur dans cette province continuent de s'appliquer.

### Conditions

1. Cette structure de cotisation s'applique uniquement à l'industrie du camionnage interprovincial.
  2. La Commission percevant les cotisations avisera la Commission auprès de laquelle l'employeur est inscrit du choix effectué par le requérant. Des renseignements supplémentaires seront fournis sur demande à la Commission auprès de laquelle l'employeur est inscrit.
  3. Cette structure de cotisation ne modifie aucunement l'option de réclamation des indemnités auprès de la compétence ou réside l'employé ou auprès de celle où la lésion est survenue.
  4. Le requérant ne peut se retirer de la structure de cotisation au cours de l'année civile. Toutefois, il peut annuler son adhésion pour l'année qui suit en donnant par écrit un préavis de deux mois (au plus tard le 31 octobre).
  5. Cette structure de cotisation est en vigueur à titre d'essai pendant une période de trois ans à compter du 1<sup>er</sup> janvier 1995.
- En vertu de l'entente interprovinciale - Structure de cotisation parallèle pour l'industrie du camionnage interprovincial, je désire/nous désirons verser des cotisations à la Commission des accidents du travail (CAT) de l'

Ontario

Signature autorisée

Richard Draper

Fonction

Président

Date

1<sup>er</sup> décembre 1994

(Verso)



# Entente relative au camionnage interprovincial

L'entente permettra de réduire le travail administratif des camionneurs et des entreprises de camionnage

Si vous êtes un de ces «chevaliers de la route» et que vous conduisez votre camion dans plus d'une province, ou encore un employeur qui engagez ces camionneurs, 1995 vous réserve de bonnes nouvelles. Les commissions du Canada travaillent présentement à une entente qui simplifiera le paiement de vos cotisations.

Selon la structure actuelle, si vous êtes un employeur qui engagez des camionneurs, vous payez votre cotisation annuelle proportionnellement pour chaque conducteur, dans les provinces dans lesquelles il conduit. À compter de 1995, vous aurez la possibilité de payer votre cotisation dans une province seulement, même si le camionneur doit conduire dans d'autres provinces.

De même, si vous êtes un exploitant indépendant qui souscrivez une protection individuelle, vous pourrez verser toutes les cotisations pour une année civile à une seule commission.

L'Association canadienne de camionnage (ACC) a communiqué avec l'Association des commissions des accidents du travail du Canada (ACATC) pour lui suggérer l'idée de rationaliser le paiement des cotisations versées par les entreprises de camionnage interprovincial et les exploitants indépendants. Malgré que certaines modifications doivent être apportées à l'entente afin de tenir compte des différences entre les provinces, dans des domaines comme le droit à des indemnités et le plafond des gains assurables, les commissions s'entendent sur le principe général. Une période d'essai de trois ans débutera le 1<sup>er</sup> janvier 1995.

## Qui est admissible?

En Ontario, pour qu'un camionneur soit admissible à la nouvelle structure de cotisation, il doit avoir un lien étroit avec cette province. Pour qu'un tel lien existe, le camionneur (qu'il travaille pour une entreprise de camionnage ou qu'il soit exploitant indépendant) doit :

- habiter en Ontario et travailler dans la province et à l'extérieur de celle-ci
- travailler habituellement en Ontario, pour un employeur dont l'établissement est situé dans cette province.

Voici des exemples de camionneurs qui n'ont pas un lien étroit avec l'Ontario et qui ne sont donc pas admissibles à la nouvelle structure de cotisation :

- les camionneurs résidant en Ontario qui ne conduisent pas en Ontario;
- les camionneurs ne résidant pas en Ontario dont le lieu de travail habituel est situé à l'extérieur de cette province;
- les camionneurs ne résidant pas en Ontario qui travaillent pour un employeur dont l'établissement est situé à l'extérieur de cette province;

## Comment présenter une demande d'indemnisation?

La nouvelle structure s'applique au versement des cotisations pour une année civile entière, mais celles-ci peuvent continuer d'être versées selon la méthode de versement habituel. Pour cette raison, vous devez faire parvenir votre demande d'adhésion à la CAT de l'Ontario avant le 1<sup>er</sup> janvier 1995. L'adhésion à la nouvelle structure ne peut être annulée durant l'année civile en cours, mais elle peut l'être pour l'année civile suivante en envoyant un avis écrit, deux mois avant la fin de l'année en cours.

Comment présenter une demande d'indemnisation? Cette nouvelle structure ne modifie en rien la procédure à suivre pour présenter une demande d'indemnisation hors-province pour les travailleurs dont le lieu de travail habituel est en Ontario. Les travailleurs ont toujours le choix de réclamer des indemnités auprès de la CAT de l'Ontario ou auprès de la commission située dans la province où l'accident survient. Si le travailleur choisit la seconde option, la CAT de l'Ontario remboursera les coûts d'indemnisation à la commission située dans la province où l'accident est survenu.

Les entreprises de camionnage seront quand même inscrites dans les autres provinces où les employés conduisent, mais la commission qui perçoit les cotisations se chargera du travail administratif se rapportant aux cotisations.

Comment s'inscrire selon la nouvelle structure? En Ontario, les exploitants indépendants qui souscrivent une protection individuelle sont automatiquement admissibles à la nouvelle structure. Les entreprises de camionnage, quant à elles, doivent présenter une demande à la CAT de l'Ontario en utilisant la Demande d'adhésion à la structure de cotisation parallèle pour l'industrie du camionnage interprovincial (voir illustration à la page 3). Cette demande est disponible au bureau local ou au bureau régional de la CAT de l'Ontario le plus près de chez vous.

Les exploitants indépendants qui n'ont pas souscrit une protection personnelle auprès de la CAT de l'Ontario.

Pour ces camionneurs, les cotisations sont versées de la même manière qu'elles l'étaient par le passé. Si une entreprise constate qu'elle n'est pas admissible en Ontario à la nouvelle structure de cotisation, elle peut vérifier auprès d'autres commissions avec lesquelles elle fait affaire pour déterminer si elle y est admissible.



## L'entente interprovinciale avantage les travailleurs et les employeurs

La Commission des accidents du travail (CAT) de l'Ontario a signé une entente prévoyant une plus grande collaboration entre les commissions des accidents du travail (commissions) du Canada, et ce aussi bien à l'avantage des employeurs que des travailleurs.

L'entente, qui s'intitule *Entente interprovinciale pour l'indemnisation des travailleurs*, combine deux ententes précédentes. La première, ratifiée en 1979, portait le titre de *Protocole d'entente entre les commissions des provinces et territoires du Canada en vue d'éviter la double imposition de cotisations*. Le but de cette entente était d'éviter la double cotisation des employeurs dont les travailleurs travaillaient dans plus d'un territoire. La seconde, approuvée en principe en 1983, s'intitulait *Entente interterritoriale en matière de lésions professionnelles*. Cette entente visait à favoriser l'entraide et la collaboration entre les commissions en ce qui a trait à la prestation de services et au versement d'indemnités aux travailleurs dont la demande d'indemnisation concernait plus d'un territoire.

Les deux premières ententes ont été combinées afin de rectifier des incohérences et d'assurer la conformité des pratiques administratives. Par ailleurs, la nouvelle entente comporte les éléments nouveaux suivants :

- un énoncé de principe;
- un mécanisme de résolution des litiges formel visant à régler des questions de nature interprovinciale qui ne sont pas réglées rapidement;
- un formulaire type permettant au travailleur d'indiquer le territoire dans lequel il choisit de réclamer des indemnités;
- des directives en matière de remboursement en vue de s'assurer que la commission située dans le territoire où la lésion ou le décès survient assume les coûts d'indemnisation.

Les objectifs de l'Entente interprovinciale pour l'indemnisation des travailleurs sont les suivants :

- éviter la double imposition de cotisations pour le même travail;
- aider les travailleurs ou leurs personnes à charge lorsqu'il y a plus d'une commission concernée dans une demande de prestations;
- créer un système qui permette à toute commission d'offrir des services aux travailleurs qui ont fait une demande d'indemnisation auprès d'une autre commission;

- fournir un mécanisme visant à résoudre les litiges entre commissions.

L'entente est divisée en six parties :

### Partie I : Exposé des principes; Définitions générales;

#### Application

La Partie I énonce en détail les objectifs et le but de l'entente : s'assurer que les questions interprovinciales sont traitées et résolues de façon efficace, compétente et rapide. On y trouve également les définitions de certains termes utilisés dans le document. Enfin, la Partie I explique à qui l'entente s'applique et à qui elle ne s'applique pas.

### Partie II : Choix du territoire; Prestations en espèces;

**Prestations en nature; Maladies professionnelles; Aggravation ou détérioration d'une incapacité**

La Partie II fournit des renseignements sur la politique relative au traitement des demandes d'indemnisation dans les cas où plus d'un territoire est concerné.

### Partie III : Cotisations

La partie III explique comment les cotisations sont prélevées dans des situations interprovinciales; on y expose également des formules de calcul des cotisations.

### Partie IV : Services administratifs; Fourniture de rapports et

**de documents; Appels**

La Partie IV porte sur les questions administratives suivantes : la non-imposition de frais administratifs en cas de traitement des demandes d'indemnisation ou des cotisations pour une commission d'un autre territoire; l'échange de rapports et de documents nécessaires à l'administration des dossiers et à la vérification des dossiers de l'employeur en matière de finances et de cotisations.

### Partie V : Résolution des litiges

La Partie V traite du processus de médiation en cas de litige pouvant survenir entre différents territoires.

### Partie VI : Mise en application de l'entente

La Partie VI énumère les dispositions générales de l'entente : les commissions acceptent de se réunir au besoin; chaque commission convient de demander à leurs corps législatifs respectifs d'apporter des modifications à leurs textes législatifs afin de les rendre conformes à la présente entente; etc.



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## Policy Report

Workers'  
Compensation  
BoardCommission  
des accidents  
du travailFebruary 1995  
Vol. 8 No. 1

## Bill 165 Highlights

Bill 165 has made some significant changes to the way the WCB operates. Here are some of the highlights.

**\$200 monthly payment  
s.147 (14)**

Section 147(14) of the *Act* instructs the WCB to make an additional payment of **up to \$200** a month to permanently disabled workers who are either currently receiving a pension supplement under section 147(4), or who are not receiving this supplement because they qualify for the federal government Old Age Security (OAS) benefits.

The WCB calculates the s.147(14) payment first, and then recalculates the s.147(4) supplement. Even if the recalculated value of the s.147(4) supplement is zero, workers remain eligible for payment under s.147(14).

To determine how much a worker is entitled to under s.147(14), the WCB adds up the worker's permanent disability pension, any current employment earnings (at either 75% of gross or 90% of net), and federal OAS benefits. If the total is less than

- 75% of the worker's gross pre-injury earnings (pre-April 1, 1985 injuries), or
  - 90% of the worker's net pre-injury earnings (post-April 1, 1985 injuries)
- the WCB makes up the shortfall, **up to \$200**.

If the sum of the permanent disability pension, current earnings (at either 75% of gross or 90% of net), **and the s.147(14) payment** is less than

- 75% of the worker's gross pre-accident earnings (pre-April 1, 1985 injuries), or
  - 90% of the worker's net pre-accident earnings (post-April 1, 1985 injuries)
- the WCB adds on the s.147(4) payment, **up to the current value of federal OAS**.

*Note: Workers who receive federal OAS are not entitled to s.147(4) payments.*

Recently, the WCB sent out questionnaires to workers who were over 65 years of age when section 147(4) benefits came into effect, and for whom insufficient earnings information was on file. Decision-makers are now processing these questionnaires and making entitlement decisions.

**New benefit-indexing  
s.148 (1)**

Bill 165 introduces a new indexing formula (Friedland) for indexing some compensation benefits and other amounts under the *Act*. Prior to this, all workers' benefits were indexed by the Consumer Price Index, (CPI), published by Statistics Canada.

The new indexing formula is: **75% of CPI minus 1:  $(.75 \times \text{CPI}) - 1$**

$$\begin{aligned} \text{Example: If CPI is 5\%, Friedland} &= (.75 \times 5) - 1 \\ &= 3.75 - 1 \\ &= 2.75 \end{aligned}$$

*Note: The indexing factor will not exceed 4 % or be less than 0 %.*

The Friedland formula will apply on January 1 of each year (beginning in 1995) to all

- dollar amounts, i.e., base amounts set out in the *Act*
- less than 100% permanent disability pensions, paid periodically
- less than 100% future economic loss (FEL) benefits, paid periodically, (except where the reduction from 100% was an adjustment for CPP/QPP income)
- FEL supplements.



## New benefit-indexing s.148 (1) (cont'd)

CPI continues to be applied on January 1 of each year to all

- survivors' benefits, paid periodically
- 100% permanent disability pensions
- 100% FELs
- non-economic loss (NEL) periodic payments
- all benefits of workers receiving some portion of the \$200 benefit.

The next issue of *Policy Report* will provide a complete list of the benefits indexed by the Friedland formula, and those indexed by CPI.

## Unpaid trainees on placements s.3.1

*Bill 165* allows training agencies who place trainees with employers without pay, to have the trainees deemed to be **workers of the training agency**, and not of the employer — referred to in this article as the "host."

In the past, the WCB identified the host as the employer, i.e., the party responsible for WCB costs. Hosts were, however, protected from workers' compensation liability for costs related to accidents involving government-funded trainees. In these cases the government paid the cost of claims.

Hosts of government-funded trainees continue to be protected from WCB liability. Now, however, with the introduction of *Bill 165* hosts of non-government-funded trainees can also be protected from WCB liability. This is possible because training agencies, specifically private vocational schools registered under Ontario's *Private Vocational Schools Act*, may elect to be deemed "employers." If an accident happens after an agency is deemed the "employer," all claim costs are charged to the training agency's own WCB account, not to the account of the host.

The option of having a trainee deemed an employee of a training agency will encourage potential hosts to extend placement opportunities to all Ontario trainees. A regulation is now being developed to make this option available to other types of training agencies, such as private vocational rehabilitation agencies.

## Return-to-work reports s.51(2)

At the request of a worker, or an employer with the consent of the worker, health professionals are to provide a return-to-work report to the worker, the employer, and the WCB. The report will contain information about the worker's ability to return to work.

This report not only allows employers and workers to more readily arrange for a return to suitable employment—without the necessity of the WCB's involvement—but it may encourage employers to develop early return-to-work programs. Experience shows that returning injured workers to work soon after the injury can reduce compensation costs, and improve the likelihood of successful vocational rehabilitation.

The WCB, in consultation with worker and employer representatives, is developing a return-to-work report. Once approved, the WCB will make the report available to workers and employers.

## VR services for employers s.53(2.1)

The WCB must contact the employer immediately after making the 45-day contact with the worker. Contact is made so the WCB can assess both the worker's and the employer's requirements for VR services and programs to workers.

## Employer co-operation in VR s.103

The *Bill* gives the WCB the authority to ensure employers participate in the VR process. Now, employers must co-operate in the design and provision of VR services and programs involving their own workers.



## Employer co-operation in VR s.103 (cont'd)

Section 103 of the *Act* states:

(4.1) If an employer fails to co-operate in vocational rehabilitation services or programs provided under section 53, the Board may add to the amount of any contribution to the accident fund for which the employer is liable an additional amount determined in accordance with subsection (4.2). The Board may assess and levy an increased assessment on the employer.

The WCB is in the process of determining the manner in which employers will be required to co-operate, and the appropriate approach to non-co-operation penalties.

## Re-employment s.54 (11.1)

*Bill 165* allows the WCB, on its own initiative, to determine if employers have fulfilled their re-employment obligations.

Until now, the WCB only made re-employment determinations when workers notified the WCB of a possible breach. Now, the WCB can make re-employment determinations whenever necessary, and does not require an application by a worker.

## Mediation s.72.1

*Bill 165* requires that the WCB provide mediation when someone objects to a WCB decision, or when a worker applies for a re-employment determination. It also allows pre-*Bill 162* cases, and a larger number of issues, to be brought to mediation. Those issues include:

- the maintenance of employment benefits
- the provision of VR services to surviving spouses
- the provision of VR services to workers and employers
- the employer's re-employment obligation
- the employer's co-operation in VR
- other issues, as determined by the WCB.

When a dispute goes to mediation the original decision-maker is now invited to participate, along with the worker, the employer and their representatives. All participation in mediation is still optional.

If mediation does not resolve a dispute the parties may ask the mediator to make a binding decision, or they may allow the dispute to go to a formal hearing.

From April 1, 1995 the WCB will be required to make a final determination, (either a mediated resolution, a mediator's decision, or a formal hearing decision) within 60 days of the WCB's receipt of the notice of objection.

## Bill 165 eliminates 'double recovery' s.9.1

*Bill 165* eliminates the opportunity for workers or their dependants to claim compensation in Ontario **and** another jurisdiction at the same time, for the same injury.

Now, a worker injured in Ontario, who may be entitled to compensation here and in another jurisdiction, must file an election form to claim compensation in Ontario. If the worker fails to file an election form, the WCB presumes that the worker does not want to claim in Ontario.

This complements s.9 of the *Act*, which requires those workers injured outside of Ontario, who may be entitled to compensation where the accident happened **and** in Ontario, to file an election form if they want to claim in Ontario.

Related amendments in the Bill change the *Act* by requiring that any compensation-related agreement that the WCB enters into with Canadian or foreign jurisdictions prevent "duplication of compensation". The Ontario WCB has entered into this kind of agreement - the *Interjurisdictional Agreement (IJA)* - with the provinces and territories of Canada (see *Policy Report* Vol.7 No.7).

For more information on *Bill 165* you may call the hotline toll free at 1-800-945-0588, or in Toronto at (416) 927-8534. Upcoming issues of *Policy Report* will cover operational policy changes resulting from *Bill 165*, as they develop. Revisions and additions to policy and guidelines will be sent to *Operational Policy* manual holders.

To purchase the manual, please call Policy Publications at (416) 927-4941.

## Notice

*The WCB will be moving this summer and fall (1995), from 2 Bloor Street East, Toronto,  
to  
200 Front Street West  
Toronto, Ontario  
M5V 3J1*

### Consultation invited

The Industrial Disease Standards Panel (IDSP)—now the Occupational Disease Panel (ODP)—recently submitted a report (Number 14) to the Ontario WCB entitled “Report to the Workers’ Compensation Board on ISDP Revisions to Schedule 3: Phase One,” dated November, 1994.

The report was published in *The Ontario Gazette* on December 17, 1994, and the deadline for submissions on this report is April 18, 1995.

Reports are available from:

Occupational Disease Panel  
69 Yonge Street, Suite 1004  
Toronto, Ontario M5E 1K3  
Tel: (416) 327-4156

If you would like to provide the WCB with comments, briefs, or submissions, send them to:

Ms. Linda Angove  
Secretary to the Board  
Workers’ Compensation Board  
2 Bloor Street East  
Toronto, Ontario M4W 3C3



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## Policy Report



**Policy Report** is published under the authority and direction of the Benefits Policy Branch of the Workers’ Compensation Board. If there is any conflict between the statements contained in this publication and the *Workers’ Compensation Act* and/or Board-approved policy documents, the *Act* or the approved document governs.

**Please address comments or inquiries to:**

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**Policy Report**  
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Workers’ Compensation Board  
2 Bloor Street East, 22nd Floor  
Toronto, Ontario M4W 3C3  
phone (416) 927-3424  
fax (416) 927-3821



À compter du 1<sup>er</sup> avril 1995, la CAT sera tenue de rendre une décision finale (soit un règlement par voie de médiation, une décision d'un médiateur ou une décision d'audience formelle) dans les 60 jours suivant la réception d'un avis de contestation.

La Loi 165 élimine toute possibilité pour un travailleur ou les personnes à sa charge de réclamer des indemnités à la fois de la CAT de l'Ontario **et** d'une autre commission des accidents du travail à l'égard d'une même lésion.

Dorénavant, un travailleur ayant subi une lésion en Ontario, qui peut avoir droit à des indemnités de la CAT de l'Ontario et d'une autre commission, doit présenter un formulaire d'option indiquant son choix de réclamer des indemnités en Ontario. Si le travailleur ne présente pas ce formulaire, la CAT présupposera qu'il a décidé de ne pas demander des indemnités en Ontario.

Cet article est le complément de l'article 9 de la Loi, selon lequel les travailleurs ayant subi une lésion à l'extérieur de l'Ontario, qui peuvent avoir droit à des indemnités dans la province, le territoire ou le pays où l'accident est survenu **et** en Ontario, sont tenus de présenter un formulaire d'option s'ils désirent réclamer des indemnités en Ontario.

D'autres modifications connexes prévues par la Loi 165 viennent modifier la Loi sur les accidents du travail. Ces modifications exigent que toute entente relative à l'indemnisation des travailleurs conclue entre la CAT et d'autres commissions du Canada ou d'un autre pays prévoit l'élimination de la «double indemnisation». La CAT de l'Ontario a conclu une telle entente - l'Entente interprovinciale pour l'indemnisation des travailleurs - avec les provinces et les territoires du Canada (voir le *Bulletin des politiques*, vol. 7, n° 7).

Pour obtenir plus de renseignements sur la Loi 165, vous pouvez téléphoner à la ligne d'assistance téléphonique en composant, sans frais, le 1-800-945-0588 ou, à Toronto, le (416) 927-8534. Dans les prochains numéros du *Bulletin des politiques*, nous vous ferons part des modifications des politiques opérationnelles qui découlent de la Loi 165 à mesure que ces modifications seront apportées. Nous enverrons aux détenteurs du *Manuel des politiques opérationnelles* les révisions et les ajouts se rapportant aux politiques et aux directives modifiées pas la Loi 165. Si vous désirez vous procurer le manuel, veuillez téléphoner aux Services de la publication des politiques en composant le (416) 927-4941.

## Consultation

Le Comité des normes en matière de maladies professionnelles (CNMP) - appelé dorénavant Comité des maladies professionnelles - a récemment présenté à la CAT de l'Ontario un rapport (N° 14) daté de novembre 1994 et intitulé «Report to the Workers' Compensation Board on ISDP Revisions to Schedule 3: Phase One».

Le rapport a été publié dans la *Gazette de l'Ontario* du 17 novembre 1994, et les observations ou mémoires portant sur ce rapport doivent parvenir à la CAT au plus tard le 18 avril 1995.

Vous pouvez obtenir une copie du rapport en communiquant avec le :  
Comité des maladies professionnelles  
69, rue Yonge, bureau 1004  
Toronto ON M5E 1K3  
Tél. : (416) 327-4156

Si vous désirez présenter à la CAT des observations ou des mémoires à ce sujet, veuillez les faire parvenir à :

M<sup>me</sup> Linda Angove  
Secrétaire du conseil  
Commission des accidents du travail  
2, rue Bloor Est  
Toronto ON M4W 3C3

## AVIS

La CAT déménage au cours de l'été et de l'automne de 1995 du 2, rue Bloor Est, Toronto à l'adresse suivante :

200, rue Front Ouest  
Toronto ON M5V 3J1

## Bulletin des politiques

Le *Bulletin des politiques* est publié par la Direction des politiques sur l'indemnisation de la Commission des accidents du travail. S'il y a contradiction entre le texte de la présente publication et la Loi sur les accidents du travail et/ou les politiques approuvées de la Commission, c'est à la Loi ou aux documents approuvés qu'il faut se référer.

Veuillez adresser vos questions ou commentaires à la :

Rédactrice  
**Bulletin des politiques**  
Publication des politiques  
Commission des accidents du travail  
2, rue Bloor Est, 22<sup>e</sup> étage  
Toronto ON M4W 3C3  
Téléphone: (416) 927-3424  
Télécopieur : (416) 927-3821

Si une question n'est toujours pas résolue à la suite de la médiation, les parties en cause peuvent demander au médiateur de rendre une décision définitive ou convenir que la question en litige soit entendue dans le cadre d'une audience formelle.

Lorsque l'on fait appel aux services de médiation pour régler une question en litige, le décideur ayant rendu la décision initiale est invité à participer à la médiation, et il en est de même pour le travailleur, l'employeur et les représentants de ces derniers. Toute participation à la médiation est néanmoins facultative.

- le maintien des avantages rattachés à l'emploi;
- l'offre de services de RP aux conjoints survivants;
- l'offre de services de RP aux travailleurs et employeurs;
- les obligations de renforcement de l'employeur;
- la participation de l'employeur à la RP;
- d'autres questions, telles qu'elles sont déterminées par la CAT.

questions suivantes peuvent faire l'objet d'une médiation :

La Loi 165 exige que la CAT fournisse des services de médiation lorsqu'il y a contestation d'une décision de la CAT ou lorsqu'un travailleur demande qu'une décision portant sur le renforcement soit rendue. Cet article de la Loi 165 prévoit également que les cas d'avant la Loi 162 et bon nombre d'autres questions soient entendues par voie de médiation. Les

Jusqu'à présent, la CAT ne rendait de décision concernant le renforcement que lorsqu'un travailleur l'avait avisé d'un manquement possible de la part de l'employeur. Maintenant la CAT peut rendre des décisions concernant le renforcement lorsqu'elle le juge nécessaire, sans que le travailleur ne soit obligé de présenter une demande en ce sens.

Aux termes de la Loi 165, la CAT peut, de sa propre initiative, décider si un employeur a rempli ses obligations en matière de renforcement.

Présentement, la CAT détermine la façon dont les employeurs seront tenus de participer à la réadaptation de leurs travailleurs et elle considère l'approche qu'elle devrait suivre en ce qui concerne l'imposition de pénalités pour non participation.

L'article 103 de la Loi précise ce qui suit :

(4.1) Si un employeur ne participe pas à des programmes ou services de réadaptation professionnelle fournis aux termes de l'article 53, la Commission peut ajouter, au montant de la cotisation que l'employeur verse à la caisse des accidents, un montant additionnel déterminé conformément au paragraphe (4.2) et le prélever sur l'employeur.

La Loi 165 donne à la CAT l'autorité de veiller à ce que les employeurs participent au processus de RP. Maintenant, les employeurs sont tenus de participer à la conception et à la prestation de programmes et de services de RP se rapportant à leurs propres travailleurs.

La CAT doit contacter l'employeur immédiatement après avoir communiqué avec le travailleur dans les 45 jours suivant le dépôt d'un avis d'accident. Ce contact est établi afin que la CAT puisse évaluer les besoins du travailleur et de l'employeur en matière de services et de programmes de RP devant être offerts aux travailleurs.

La CAT, en consultation avec les représentants des travailleurs et des employeurs, élabore un rapport concernant le retour au travail. Une fois approuvé, ce rapport sera mis à la disposition des travailleurs et des employeurs.

L'on peut réduire les coûts d'indemnisation et améliorer les chances de réussite de la réadaptation professionnelle en permettant aux travailleurs de retourner travailler tôt après leur lésion.

Rapports concernant le retour au travail Par. 51(2) (suite)

Services de réadaptation professionnelle (RP) pour les employeurs Par. 53 (2.1)

Participation de l'employeur à la RP Art. 103

Rengancement Par. 54 (11.1)

Médiation Art. 72.1



La formule Friedland s'appliquera le 1<sup>er</sup> janvier de chaque année (à compter de 1995) dans tous les cas suivants :

- les montants exprimés en dollars, c.-à-d. les montants de base énoncés dans la Loi;
- les pensions d'invalidité permanente de moins de 100 % qui sont versées mensuellement;
- les indemnités pour perte économique future (PEF) de moins de 100 % qui sont versées mensuellement (sauf lorsque la réduction de l'indemnité de 100% est attribuable à un rajustement du revenu provenant du Régime de pensions du Canada [RPC] ou du Régime de rentes du Québec [RRQ] ;
- les suppléments pour PEF;

L'IPC continuera de s'appliquer le 1<sup>er</sup> janvier de chaque année dans tous les cas suivants :

- les prestations de survivant versées mensuellement;
- les pensions d'invalidité permanente de 100 %;
- les indemnités pour PEF de 100 %;
- les indemnités pour perte non économique (PNE) qui sont versées mensuellement;
- toutes les indemnités versées aux travailleurs qui reçoivent une portion du paiement additionnel de 200 \$.

Une liste détaillée des indemnités indexées en fonction de la formule Friedland et de celles indexées en fonction de l'IPC figurera dans le prochain numéro du *Bulletin des politiques*.

En vertu de la Loi 165, l'organisme de formation qui place des personnes en formation non rémunérée auprès d'employeurs peut choisir de faire considérer ces personnes en tant que **travailleurs de l'organisme de formation**, et non de l'employeur - ci-après appelé «agent d'accueil».

Par le passé, la CAT considérait l'agent d'accueil comme l'employeur, c.-à-d. comme la partie responsable des coûts relatifs à la CAT. Toutefois, les agents d'accueil étaient protégés contre toute responsabilité en matière d'indemnisation reliée aux accidents que subissaient les personnes en formation financées par le gouvernement. En pareils cas, le gouvernement assumait les coûts d'indemnisation.

Les agents d'accueil des personnes en formation financées par le gouvernement continuent d'être protégés contre toute responsabilité en matière d'indemnisation. Toutefois, conformément à la Loi 165, les agents d'accueil de personnes en formation non financées par le gouvernement peuvent également être protégés contre toute responsabilité envers la CAT. Cette nouvelle mesure est possible étant donné que les organismes de formation, plus précisément les écoles privées de formation professionnelle inscrites aux termes de la Loi sur les écoles privées de formation professionnelle de l'Ontario, peuvent choisir d'être réputés l'«employeur» des personnes en formation. Si un accident survient après qu'un tel organisme est réputé l'«employeur», tous les coûts d'indemnisation sont alors imputés au compte même de l'organisme de formation et non au compte de l'agent d'accueil.

Le choix qu'a l'organisme de formation d'avoir une personne en formation considérée comme son employé incitera les agents d'accueil possibles à offrir des occasions de placement à toutes les personnes en formation de l'Ontario. Un règlement, qui est présentement en voie d'élaboration, visera à offrir ce choix à d'autres genres d'organismes de formation, tels les organismes privés de réadaptation professionnelle.

À la demande du travailleur, ou de l'employeur ayant le consentement de ce dernier, les professionnels de la santé doivent fournir au travailleur, à l'employeur et à la CAT un rapport concernant le retour au travail. Ce rapport renfermera des renseignements sur la capacité du travailleur à retourner travailler.

En plus d'aider l'employeur et le travailleur à préparer plus aisément la reprise d'un emploi approprié, et ce sans que la CAT n'ait besoin d'intervenir, un tel rapport peut inciter les employeurs à élaborer des programmes de prompt retour au travail. L'expérience démontre que

## La Loi 165 : Les principales dispositions

En vertu de la Loi 165, d'importantes modifications ont été apportées au fonctionnement de la Commission des accidents du travail (CAT). Voici quelques-unes des principales dispositions prévues par la Loi 165.

**Paiement mensuel de 200 \$ Par. 147 (14)**

Aux termes du paragraphe 147 (14) de la Loi sur les accidents du travail (la Loi), la CAT est tenue de verser un paiement additionnel **pouvant atteindre 200 \$** par mois aux travailleurs atteints d'une invalidité permanente qui reçoivent actuellement le supplément de pension prévu au paragraphe 147 (4) de la Loi ou qui ne reçoivent pas ce supplément parce qu'ils sont admissibles à des prestations de sécurité de la vieillesse du gouvernement fédéral.

La CAT calcule d'abord le paiement découlant du paragraphe 147 (14) et elle recalculé ensuite le supplément prévu au paragraphe 147 (4). Même si le montant du supplément aux termes du paragraphe 147 (4), une fois recalculé, est de zéro, le travailleur demeure admissible au paiement prévu au paragraphe 147 (14).

Pour déterminer le montant auquel un travailleur a droit en vertu du paragraphe 147 (14), la CAT additionne le montant de la pension d'invalidité permanente du travailleur, le montant des gains qu'il touche actuellement dans le cadre de son emploi, le cas échéant (soit 75 % des gains bruts ou 90 % des gains nets) et toute prestation de sécurité de la vieillesse versé par le gouvernement fédéral. Si le total de tous ces éléments est inférieur à :

- 75 % des gains bruts avant la lésion (lésions survenues avant le 1<sup>er</sup> avril 1985); ou
- 90 % des gains nets avant la lésion (lésions survenues le 1<sup>er</sup> avril 1985 ou après cette date),

la CAT comble la différence, **jusqu'à concurrence de 200 \$**.

Si la somme de la pension d'invalidité permanente, des gains actuels (soit 75 % des gains bruts ou 90 % des gains nets), et du **paiement prévu au paragraphe 147 (14)** est inférieure à :

- 75 % des gains bruts avant la lésion (lésions survenues avant le 1<sup>er</sup> avril 1985); ou
- 90 % des gains nets avant la lésion (lésions survenues le 1<sup>er</sup> avril 1985 ou après cette date),

la CAT ajoute à la somme obtenue le supplément prévu au paragraphe 147 (4), **jusqu'à concurrence de la valeur actuelle des prestations de sécurité de la vieillesse**.

*Remarque : Les travailleurs qui reçoivent des prestations de sécurité de la vieillesse n'ont pas droit au supplément prévu au paragraphe 147 (4) de la Loi.*

La CAT a récemment envoyé un questionnaire à tous les travailleurs qui étaient âgés de plus de 65 ans au moment où le supplément prévu au paragraphe 147 (4) est entré en vigueur et dont le dossier ne renfermait pas des renseignements suffisants sur leurs gains. Les décideurs de la CAT passent maintenant en revue ces questionnaires et rendent des décisions sur l'admissibilité de ces travailleurs.

**Nouvelle indexation des indemnités Par. 148 (1)**

La Loi 165 prévoit l'indexation de certaines indemnités de la CAT ainsi que d'autres montants prévus par la Loi selon une nouvelle formule d'indexation, appelée formule Friedland. Avant l'adoption de cette nouvelle formule, toutes les indemnités versées aux travailleurs étaient indexées en fonction de l'Indice des prix à la consommation (IPC) publié par Statistique Canada.

La nouvelle formule d'indexation correspond à : **75 % de l'IPC moins 1 : (0,75 x IPC) - 1.**

**Exemple : Si l'IPC est de 5 %, la formule Friedland = (0,75 x 5 %) - 1 = 3,75 - 1 = 2,75**

*Remarque : Le facteur d'indexation ne sera pas supérieur à 4 % ni inférieur à 0 %.*



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## Policy Report

Workers'  
Compensation  
BoardCommission  
des accidents  
du travailMay 1995  
Vol. 8, No. 2

# New indexing factor introduced

On January 1 each year, the WCB indexes workers' compensation benefits, pensions, average earnings, and the dollar amounts set out in the *Act* so that the relative purchasing power of benefit dollars is protected against the effects of inflation.

In preparation for the indexing that occurs annually on January 1, the WCB

- establishes a new *Net Average Earnings Table* (p. 2), used to redetermine workers' net average earnings (NAE)
- adjusts all the dollar amounts (maximum and minimum benefit levels) set out in the *Act*, including the earnings ceiling
- updates the computer programs that run the myriad calculations that control the cheque-writing systems, and
- keeps workers informed by preparing and mailing letters (in December) explaining any increases/decreases to their January cheques.

Of course, this year just to keep everyone on their toes, Bill 165 added something new— another indexing factor.

## Two indexing factors as of January 1, 1995

Since 1986, the *Act* legislated the WCB to use the Consumer Price Index (CPI) as its indexing factor. But this year, it was legislated to use a second indexing factor (based on the CPI), referred to as the Friedland Formula. This new factor (described in the next column) is now used to index most benefits, but the CPI is still used in some cases. (See chart insert.)

## Consumer Price Index (CPI)

To come up with the CPI, Statistics Canada keeps track of the purchasing power of the dollar each month by monitoring the cost of consumer products. The Statistics Canada "shopping basket" contains such diverse items as new vehicles, auto

insurance, gasoline, rental charges for accommodation, fresh fruits and vegetables, etc. After making seasonal adjustments for items like fruits and veggies—the cost of which go down in summer and up in winter—the difference between the price of items in the 12-month period just assessed and the previous 12 months is tallied and averaged. The overall average percentage

by which the cost of the items in the shopping basket rose or fell is the CPI. The WCB uses the CPI in effect on October 31 of the previous year.

The WCB continues to use the CPI to index all

- survivors' benefits paid periodically
- 100% pensions paid under the pre-1989 *Act*
- 100% FEL benefits (excluding supplements) including those adjusted to account for a CPP/QPP benefit, and
- all benefit payments to workers receiving a s.147 (14) payment.

Although most of us think the cost of living always goes up, it does go down sometimes, as in 1994 when, for the first time in years, the CPI was a negative value (-.2%). When this happens, workers' benefits and pensions, indexed by CPI, are protected since the *Act* states that the indexing factor cannot be less than 0 per cent.

## New indexing factor

The WCB is now legislated to use the Friedland Formula to arrive at the indexing factor for benefits and pensions that are **not** indexed by

CPI. This formula yields a lesser percentage than CPI: **(75% of CPI) - 1%**.

When you apply Friedland, using the CPI of minus .2%, you get: .75 X (-.002) - .01 = **-.0115**. But, as with the CPI, the *Act* sets limits on this indexing factor. It cannot be less than 0, or more than 4%. So, this year the amount of workers' benefits were not affected. (Note: Despite zero indexing, many workers' cheques were

### S.148(2)

*On the 1st day of January in each year, the Board shall,*

- adjust the dollar amounts set out in this Act...*
- adjust average earnings by applying the indexing factor to the average earnings...and the Board shall make consequential changes to the compensation payable....*

### S.151(1)

*On the 1st day of January in each year, the Board shall redetermine the net average earnings of a worker under section 41 for payments accruing after the date of re-determination by deducting from the earnings of a worker,*

- the probable income tax payable by the worker on the worker's earnings for the current year;*
- the probable Canada Pension Plan premiums payable by the worker for the current year; and*
- the probable unemployment insurance premiums payable by the worker for the current year.*

### S.151(2)

*The table established by subsection 41(2) shall set out the re-determinations calculated under subsection (1).*

### S.41(2)

*The Board shall on the 1st day of January each year establish a schedule setting forth a table of net average earnings...and such schedule shall be deemed conclusive and final.*

marginally lower due to a Revenue Canada increase in income tax, CPP, and UIC contributions.)

The new index factor—(75% of CPI) minus 1% —is applied to all

- dollar amounts, i.e., base amounts (minimums and maximums, lump sums, etc.) set out in the *Act*
- less than 100% pensions (unless the worker is in receipt of s.147(4) or s.147(14) benefits)
- less than 100% FEL benefits, paid periodically.

### Other steps in indexing

To index benefits and pensions (that are less than 100%), the WCB always indexes the workers' gross earnings first, and then redetermines the NAE, before recalculating the benefit or pension.

### The Net Average Earnings Table

To redetermine workers' NAE on January 1, the WCB deducts from workers' gross earnings their probable income tax, Canada Pension Plan, and Unemployment Insurance premiums. To simplify the process, the WCB establishes a new conversion table each year, derived from Revenue Canada data. The table lists gross weekly earnings in the first column, starting at \$1.00 and going up to \$1065.00. Listed across the top of the table are net exemption codes (NECs). Once you find the worker's gross weekly wage, you can find the net weekly wage under the worker's NEC. (Codes are reported on workers' Revenue Canada TD1 forms, and the WCB's Employer's Report of Injury/Disease, Form 7.)

### Indexing temporary benefits

If a worker's pre-injury earnings information pre-dates January 1 of the year in which the benefit is calculated, the WCB indexes the

earnings for the intervening years by the factor in use on each January 1. Today, for example, if a worker's temporary benefit is calculated or recalculated, and the earnings information dates back to September 1993, the WCB indexes the gross earnings by CPI (multiplies gross wage by  $1 + \text{CPI}$ ) for January 1, 1994, and by 75% of CPI minus 1% for January 1, 1995.

### FEL indexing adjustment

In applying s.43(3), pre-injury earnings are indexed by CPI (or multiplied by  $1 + \text{CPI}$ ). However, once the FEL calculation is done, the result for all workers with less than 100% benefits must be adjusted according to s.43(4) of the *Act* by multiplying the dollar value of the benefit by

$$\frac{1 + (75\% \text{ of CPI}) - 1\%}{1 + \text{CPI}}$$

*Policy Report*, Vol. 8, No 4, will be devoted to FEL calculation and indexing.

The enclosed chart lists all the benefits by section of the *Act*; describes the dollar amounts; indicates the indexing factor used; and provides the 1995 (indexed) amounts that are now in effect. For more information on indexing, refer to the *Operational Policy* manual.

For a copy of the *Table of Net Average Earnings*, call 1-800-387-0750, ext. 3500; or, if you are in the 416 area, dial 927-3500.

### NOTICE TO SUBSCRIBERS

If you save your issues of *Policy Report*, you can get an up-to-date index by calling the number listed below.

## Notice

*The WCB will be moving this summer and fall (1995), from 2 Bloor Street East, Toronto, to 200 Front Street West Toronto, Ontario M5V 3J1*

*The move will occur in phases. A schedule will appear in the next issue of Policy Report.*

## Policy Report

Workers' Compensation Board  
Commission des accidents du travail

**Policy Report** is published under the authority and direction of the Benefits Policy Branch of the Workers' Compensation Board. If there is any conflict between the statements contained in this publication and the *Workers' Compensation Act* and/or Board-approved policy documents, the *Act* or the approved document governs.

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Articles de la Loi	Description et montants prévus par la Loi	Facteur d'indexation IPC (75 % CPI) - 1 % Friedland	Montants pour 1995
35 (1) a)	Paiement forfaitaire au conjoint survivant : Montant de base = 40 000,00 \$ Majoration/diminution de 1 000,00 \$ pour conjoint de moins/de plus de 40 ans, pour chaque année entre son âge et l'âge de 40 ans. Maximum = 60 000,00 \$ Minimum = 20 000,00 \$	<div>✓</div> <div>✓</div> <div>✓</div> <div>✓</div>	54 949,79 \$  1 373,74 \$ 82 424,66 \$ 27 474,88 \$
35 (4)	Versements périodiques au conjoint survivant avec enfant(s) de moins de 19 ans : 90 % des gains moyens nets du travailleur, au moment de la lésion, sous réserve du minimum prévu au par. 39 (3).	✓	
35 (5)	Versements périodiques au conjoint survivant sans enfants : 40 % des gains moyens nets du travailleur, au moment de la lésion, plus/moins 1 % pour chaque année que le conjoint a moins/plus de 40 ans. Minimum = 20 % des gains moyens nets Maximum = 60 % des gains moyens nets	✓	
35 (6) a)	Versements périodiques à un seul enfant à charge survivant (aucun conjoint survivant) : 30 % des gains moyens nets du travailleur, au moment de la lésion.	✓	
35 (6) b)	Versements périodiques à plus d'un enfant à charge survivant (aucun conjoint survivant) : 30 % des gains moyens nets du travailleur, au moment de la lésion, pour le 1 <sup>er</sup> enfant, plus 10 % pour chacun des autres enfants, jusqu'à un maximum de 90 %.	✓	
35 (7)	Paiement forfaitaire total de 40 000,00 \$ à l'enfant ou aux enfants (aucun conjoint survivant).	✓	54 949,79 \$
35 (8)	Versements périodiques à d'autres personnes à charge (aucun conjoint ni enfant survivant) : établis par la Commission, ne dépassant pas 50 % des gains moyens nets du travailleur, au moment de la lésion.	✓	
35 (9)	Frais d'inhumation ou d'incinération : minimum = 1 500,00 \$.	✓	2 060,61 \$
35 (11)	Versements périodiques pour l'éducation d'un ou des enfant(s) à charge âgé(s) de plus de 19 ans : 10 % des gains moyens nets du travailleur, au moment de la lésion, jusqu'à un maximum de 90 %.	✓	
35 (13)	Versements périodiques à une personne qui tient lieu de père ou de mère à un ou des enfant(s) survivant(s), jusqu'à un maximum de 90 % des gains moyens nets du travailleur, au moment de la lésion.	✓	
35 (17)	Indemnités versées à plus d'une personne, à titre de conjoint : • Total des versements périodiques : jusqu'à un maximum de 90 % des gains moyens nets du travailleur, au moment de la lésion. • Montant forfaitaire : maximum = 60 000,00 \$.	<div>✓</div> <div>✓</div>	82 424,66 \$
37 (1)	Indemnités d'invalidité totale temporaire : 90 % des gains moyens nets du travailleur, au moment de la lésion, sous réserve du minimum prévu au par. 39 (1).	✓	
37 (2) a)	Indemnités d'invalidité partielle temporaire : 90 % de la différence entre les gains moyens nets du travailleur, avant la lésion, et le montant qu'il est capable de gagner après la lésion.	✓	
38	Montant maximal des gains moyens : 175 % du salaire moyen prévalant dans l'industrie en Ontario durant l'année où l'accident est survenu. Pour obtenir plus de renseignements sur le montant maximal des gains moyens, consulter la politique 05-01-02 du <a href="#">Manuel des politiques opérationnelles</a> .	1,75 X 31 634,03 \$ = 55 400,00 \$	

**Section  
of the Act**

**Description**

**Indexing factor**  
**CPI ( 75% CPI ) -1%**  
Friedland

**1995**  
**\$ - Amount**

35(1)(a)	Lump sum to surviving spouse: Base amount = \$40,000 Age factor: Plus/minus \$1,000 for each year spouse is under/over age 40 Maximum lump sum = \$60,000 Minimum lump sum = \$20,000	✓ ✓ ✓ ✓	54,949.79  1,373.74 82,424.66 27,474.88
35(4)	Periodic payments to surviving spouse with a child under age 19: 90% of worker's net average earnings (NAE) at the time of injury, subject to minimum stated in s.39(3)	✓	
35(5)	Periodic payments to surviving spouse with no children: 40% of worker's NAE at the time of injury plus/minus 1% for every year spouse is over/under age 40 Minimum = 20% NAE Maximum = 60% NAE	✓	
35(6)(a)	Periodic payments to one surviving dependent child (no spouse): 30% of worker's NAE at the time of injury	✓	
35(6)(b)	Periodic payments to more than one surviving dependent child (no surviving spouse): 30% of worker's NAE at the time of injury for the 1st child + 10% for each additional child, to maximum of 90%	✓	
35(7)	Aggregate lump sum payment for children when there is no surviving spouse = \$40,000	✓	54,949.79
35(8)	Periodic payments to other dependents (no spouse or children): determined by WCB policy, but not to exceed 50% of worker's NAE at the time of injury	✓	
35(9)	Minimum burial or cremation expenses = \$1500	✓	2,060.61
35(11)	Periodic payments for continuing education of children over age 19: 10% of worker's NAE for each child, to maximum of 90%	✓	
35(13)	Periodic payments to person parenting surviving children: Not to exceed 90% of worker's NAE at the time of injury	✓	
35(17)	When more than one person is entitled to receive periodic and lump sum payments as a spouse, the total periodic payment may not exceed • 90% of worker's NAE at the time of injury, and • the total lump sum payment may not exceed \$60,000	✓ ✓	82,424.66
37(1)	Temporary total disability benefit: 90% of worker's NAE at time of injury, subject to minimum stated in 39(1)	✓	
37(2)(a)	Temporary partial disability benefit: 90% of the difference between pre- and post-injury NAE	✓	
38	Maximum earnings ceiling: 175% of the avg. industrial wage for Ontario for the year in which the accident takes place For more information about maximum earnings ceiling, see <i>Operational Policy</i> manual document 05-01-02.		1.75 X \$31,634.03 = \$55,400.00





**Section  
of the Act**

**Description**

**Indexing factor  
CPI ( 75% CPI )-1%**

**1995  
\$ - Amount**

39(1)	The minimum temporary total disability benefit to a worker is • \$10,500 per year when the NAE are equal to or more than \$10,500 or • the actual NAE if earnings are less than \$10,500 per year	✓	15,145.55
39(3)	The minimum compensation for spouse and children under s.35(4),(5),(6) = \$11,025	✓	15,145.55
42	NEL (non-economic loss) benefit: Base amount = \$45,000 Age factor: Plus/minus \$1,000 for each year worker is under/over age 45, to a maximum of \$20,000.	✓ ✓	50,973.44 1,133.13 to 22,654.41
	The threshold dollar amount (\$10,000) determines method of payment: The benefit is paid as a lump sum if it is less than or equal to threshold	✓	11,327.20
43(6.1)	FEL payments to workers with 100% benefits (with no supplements added in), including those adjusted to account for a CPP/QPP benefit for the specific impairment  FEL payments to workers with less than 100% benefits	✓ ✓	
43(9)	FEL supplement for workers participating in VR	✓	
44(1)	Retirement Pension: <i>Payments are not subject to WCB indexing. Workers choose, before age 65, the payment scheme they wish applied</i>		
44(7)	The threshold dollar amount (\$1,000) determines method of payment: Pension is paid as a lump sum if it yields less than threshold per year	✓	1,132.74
50(3)	Maximum clothing allowance: • upper limb prosthesis • lower limb prosthesis/back brace/leg brace	✓ ✓	252.77 505.55
54	Re-employment payments: 90% of NAE	✓	
147(2)	Temporary supplement for workers likely to benefit from vocational rehabilitation (VR)	✓	
147(4)	Permanent supplement for workers unlikely to benefit from VR, or whose earnings after VR are not likely to approximate pre-injury NAE	*	
147(14)	Statutory dollar amount = \$200 per month Periodic payments	✓ ✓	
45(pre-'89)	Permanent disability payments: 90% of pre-injury NAE	✓**	
43(pre-'85)	Permanent disability payments: 75% of pre-injury gross average earnings	✓**	

\* This benefit is not indexed by the WCB. It is adjusted quarterly when OAS benefits are indexed.  
\*\* These benefits are indexed by CPI if the worker is receiving the s.147(14) benefit.

Articles de la <u>Loi</u>	Description et montants prévus par la <u>Loi</u>	Facteur d'indexation IPC (75 % CPI) - 1 % Friedland	Montants pour 1995
39(1)	L'indemnité minimale payable en cas d'invalidité totale temporaire correspond : à 10 500,00 \$ par année si les gains moyens nets au moment de l'accident sont de 10 500,00 \$ ou plus; au montant des gains moyens nets au moment de l'accident si ceux-ci sont inférieurs à 10 500,00 \$ par année.	✓	15 145,55 \$
39 (3)	L'indemnité minimale à laquelle ont droit les enfants à charge, en vertu des par. 35 (4), (5), (6), est de 11 025,00 \$ par année.	✓	15 145,55 \$
42	Indemnité pour perte non économique (PNÉ) : Montant de base = 45 000,00 \$ Facteur d'âge : plus/moins 1 000,00 \$ pour chaque année que le travailleur a moins/plus de 45 ans; maximum = 20 000,00 \$ Seuil de 10 000,00 \$ servant à déterminer le mode paiement L'indemnité est versée sous forme de paiement forfaitaire si elle est inférieure ou égale au seuil.	✓ ✓ ✓ ✓ ✓	50 973,44 \$ 1 133,13 \$ 22 654,41 \$ 11 327,20 \$
43 (6.1)	Versements aux travailleurs recevant une indemnité pour PÉF de 100 % (sans supplément) y compris celles rajustées en fonction des prestations aux titres du RPC/RRQ. Versements aux travailleurs recevant une indemnité pour PÉF de moins de 100 %.	✓ ✓	
43 (9)	Supplément pour PÉF versé aux travailleurs participant à un programme de réadaptation professionnelle.	✓	
44 (1)	Versements de pension de retraite : <i>Les versements ne sont pas indexés par la CAT. Avant d'atteindre l'âge de 65 ans, les travailleurs choisissent le mode de paiement qu'ils désirent.</i>		
44 (7)	Seuil de 1 000,00 \$ déterminant si la pension est versée sous forme de paiement forfaitaire.	✓	1 132,74 \$
50 (3)	Allocation vestimentaire : Montant maximal : - prothèse à un membre supérieur - prothèse à un membre inférieur, corset ou attelle à la jambe	✓ ✓	252,77 \$ 505,55 \$
54	Indemnités versées dans le cas d'un rengagement : 90 % des gains moyens nets.	✓	
147 (2)	Supplément temporaire versé aux travailleurs qui profiteront vraisemblablement d'un programme de réadaptation professionnelle.	✓	
147 (4)	Supplément permanent versé aux travailleurs qui ne profiteront vraisemblablement pas d'un programme de réadaptation professionnelle ou qui, aux termes d'un tel programme, ne retrouveront pas la capacité de gain équivalant à leurs gains moyens nets d'avant l'accident.	*	
147 (14)	Montant additionnel de 200,00 \$ par mois. Versements périodiques.	✓ ✓	
45 ( <u>Loi</u> d'av. 1989)	Pension d'invalidité permanente : 90 % des gains moyens nets d'avant l'accident.	✓**	
43 ( <u>Loi</u> d'av. 1985)	Pension d'invalidité permanente : 75 % des gains moyens bruts d'avant l'accident.	✓**	

\* Ce supplément n'est pas indexé par la CAT. Il est rajusté tous les trois mois en fonction de la pension de la sécurité de la vieillesse.

\*\* Cette pension est indexée en fonction de l'IPC si le travailleur reçoit le supplément prévu au par. 147 (14) de la Loi.



## Un nouveau facteur d'indexation

Aux termes de la Loi, la CAT est maintenant tenue d'utiliser la formule Friedland comme facteur d'indexation pour les indemnités et les pensions qui **ne sont pas** indexées selon l'IPC. Le pourcentage obtenu par cette formule est moindre que l'IPC : (75 % de l'IPC) - 1 %.

Lorsqu'on applique la formule Friedland en utilisant l'IPC de - ,2 %, on obtient :  $75 \times (-,002) - ,01 = -,0115$ . Cependant, comme dans le cas de l'IPC, la Loi prévoit que ce facteur d'indexation ne peut être inférieur à 0 % ni supérieur à 4 %. En conséquence, le nouveau facteur n'a pas eu d'effets sur le montant des indemnités versées aux travailleurs cette année. (À noter que, malgré l'indexation de 0 %, le montant de nombreux chèques versés aux travailleurs était légèrement plus bas en raison d'augmentations imposées par Revenu Canada sur les cotisations aux titres de l'impôt sur le revenu, du RPC et de l'assurance-chômage.)

- La CAT utilise le nouveau facteur d'indexation, (75 % de l'IPC) - 1 %, pour indexer :
- les montants exprimés en dollars dans la Loi (minimum et maximum, paiements forfaitaires, etc.)
  - les pensions de moins de 100 % (à moins que le travailleur ne reçoivent les indemnités prévues au par. 147 (4) ou (14) de la Loi);
  - les versements périodiques des indemnités pour PEF de moins de 100 %.

## Précision sur le processus d'indexation

Au cours du processus d'indexation des indemnités et des pensions (de moins de 100 %), la CAT indexe d'abord les gains bruts du travailleur, puis détermine à nouveau ses gains moyens nets avant de recalculer les indemnités ou les pensions.

## La Table des gains moyens nets

Afin de déterminer à nouveau les gains moyens nets du travailleur au 1<sup>er</sup> janvier, la CAT déduit des gains bruts du travailleur ses contributions probables aux titres de l'impôt sur le revenu, du Régime de pensions du Canada et de l'assurance-chômage. Pour simplifier le processus, la CAT établit chaque année une nouvelle table de conversion, à partir des données de Revenu Canada. En première colonne de la table, on trouve les gains bruts hebdomadaires, de 1,00 \$ à 1 065,00 \$. Les codes d'exemption nette (CEN) sont indiqués horizontalement au haut de la table. Une fois le salaire hebdomadaire brut repéré, on trouve le salaire hebdomadaire net du travailleur sous le CEN approprié. (Le CEN est indiqué sur le feuillet TDI de Revenu Canada et sur l'Avis de lésion ou de maladie (employeur) — *Formule 7* de la CAT.)

## L'indexation des indemnités temporaires

Si les renseignements sur les gains d'accident datent d'avant le 1<sup>er</sup> janvier de l'année durant laquelle les indemnités sont calculées, la CAT indexe les gains pour les années en cause au moyen du facteur en application au 1<sup>er</sup> janvier de chaque année. Si par exemple la CAT calcule ou recalcule aujourd'hui

## L'indexation de l'indemnité pour PEF

les indemnités temporaires d'un travailleur, et que les renseignements sur les gains datent de septembre 1993, elle indexe les gains bruts selon l'IPC (gains bruts  $X (1 + IPC)$ ) pour le 1<sup>er</sup> janvier 1994, puis selon la formule Friedland (gains bruts  $X [(75 \% \text{ de l'IPC}) - 1 \%)$ ) pour le 1<sup>er</sup> janvier 1995.

En appliquant le par. 43 (3) de la Loi, les gains d'avant l'accident sont indexés selon l'IPC, c.-à-d. multipliés par  $(1 + IPC)$ . Une fois l'indemnité pour PEF calculée, si elle est de moins de 100 %, elle doit être rajustée aux termes du par. 43 (4) de la Loi. Ainsi, le résultat doit être multiplié par la formule suivante :

$$\frac{1 + (75\% \times IPC) - 1\%}{1 + IPC}$$

Le *Bulletin des politiques*, Vol. 8, n° 4 sera consacré au calcul et à l'indexation de l'indemnité pour PEF.

Dans le tableau ci-inclus, vous trouverez : la liste de toutes les indemnités selon l'article ou le paragraphe de la Loi auquel elles se rapportent; les montants exprimés en dollars dans la Loi; le facteur d'indexation utilisé; les montants indexés en vigueur pour 1995. Si vous désirez obtenir plus de renseignements sur l'indexation, veuillez consulter le *Manuel des politiques opérationnelles* de la CAT.

Pour obtenir une copie de la Table des gains moyens nets, téléphonez au 1-800-387-0750, poste 3500; si vous êtes dans la région desservie par l'indicatif 416, composez le 927-3500.

## Avis

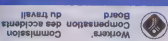
La CAT déménage au cours de l'été et de l'automne 1995 du 2, rue Bloor Est,

Toronto, à l'adresse suivante :

200, rue Front Ouest, Toronto ON M5V 3J1

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**Bulletin des politiques**



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Le **Bulletin des politiques** est publié par la Direction des politiques sur l'indemnisation de la Commission des accidents du travail. S'il y a contradiction entre le texte de la présente publication et la Loi sur les accidents du travail et/ou les politiques approuvées de la Commission, c'est à la Loi ou aux documents approuvés qu'il faut se référer.



## Introduction d'un nouveau facteur d'indexation

L'indice des prix à la consommation (IPC) Pour établir l'IPC, Statistique Canada suit l'évolution du pouvoir d'achat du dollar d'un mois à l'autre, en observant le coût des produits de consommation. Le « panier de produits et de services » de Statistique Canada contient des biens et services variés : nouveaux véhicules automobiles, assurance-automobile, essence, location de logement, fruits et légumes frais, etc. Après avoir effectué un rajustement saisonnier pour des produits comme les fruits et légumes, dont les prix diminuent en été et augmentent en hiver, Statistique Canada calcule la différence entre les prix des produits pour la période de 12 mois venant d'être évaluée et ceux pour la période précédente, puis en fait la moyenne. Le pourcentage global moyen d'augmentation ou de diminution du prix des produits contenus dans le panier de biens et de services est l'IPC. Pour une année donnée, la CAT utilise l'IPC en vigueur au 31 octobre de l'année précédente. La CAT continue d'utiliser l'IPC pour indexer :

- les versements périodiques des prestations de survivants;
- les pensions de 100 % versées en vertu de la Loi d'avant 1989;
- les indemnités pour PEF de 100 % (sans supplément), y compris celles rajustées en fonction des prestations versées aux titulaires du RPC et du RRQ;
- les versements d'indemnités aux travailleurs recevant le montant prévu au par. 147(14) de la Loi.

La plupart d'entre nous pensons que le coût de la vie va toujours en augmentant. Il arrive toutefois qu'il diminue. En 1994 par exemple l'IPC était négatif (-,2 %) pour la première fois depuis plusieurs années. Dans un tel cas, les indemnités et les pensions indexées selon l'IPC sont protégées car la Loi prévoit que ce facteur d'indexation ne peut être de moins de 0 %.

Le 1<sup>er</sup> janvier de chaque année, la Commission des accidents du travail (CAT) indexe les indemnités, les pensions, les gains moyens des travailleurs ainsi que les montants exprimés en dollars dans la Loi sur les accidents du travail (la Loi). Cette indexation vise à protéger contre les effets de l'inflation le pouvoir d'achat relatif des indemnités (dollars).

Pour se préparer au rajustement annuel du 1<sup>er</sup> janvier, la CAT :

- établit une nouvelle Table des gains moyens nets (décrite à la p. 2) pour déterminer à nouveau les gains moyens nets du travailleur;
- rajuste tous les montants exprimés en dollars (maximum et minimum) dans la Loi, y compris le plafond des gains assurables;
- met à jour les programmes informatiques permettant d'effectuer les multiples calculs régissant la production des chèques;
- tient les travailleurs informés au moyen de lettres (qu'elle envoie en décembre) expliquant la nature des augmentations ou des diminutions des montants figurant sur leur chèque de janvier.

### Deux facteurs d'indexation à compter du 1<sup>er</sup> janvier 1995

Fait nouveau cette année : La Loi 165 introduit un nouveau facteur d'indexation.

**148 (2)**  
La Commission, le 1<sup>er</sup> janvier de chaque année, prend les mesures suivantes :

a) elle rajuste les montants exprimés en dollars dans la présente loi (...)

b) elle rajuste les gains moyens au moyen du facteur d'indexation qu'elle applique aux gains moyens rajustés (...)

et apporte les changements qui en résultent aux indemnités payables (...)

**151 (1)**  
La Commission, le 1<sup>er</sup> janvier de chaque année, établit à nouveau les gains moyens nets d'un travailleur aux termes de l'article 41, en ce qui concerne les paiements accumulés après la date où les gains moyens sont établis à nouveau, en déduisant des gains du travailleur :

a) l'impôt probable que le travailleur devra payer sur ses gains pour l'année courante;

b) les cotisations probables que le travailleur devra faire au Régime de pensions du Canada pour l'année courante;

c) les cotisations probables que le travailleur devra faire au titre de l'assurance-chômage pour l'année courante.

**(2)** Le barème établi aux termes du paragraphe 41 (2) précise les nouveaux gains moyens calculés en vertu du paragraphe (1).

**41 (2)**  
Chaque année, le 1<sup>er</sup> janvier, la Commission établit un barème des gains moyens nets (...). Ce barème est réputé définitif.

Depuis 1986, la CAT était tenue par la Loi d'utiliser l'indice des prix à la consommation (IPC) comme facteur d'indexation. Cette année, la Loi prévoit que la CAT utilise un second facteur d'indexation, basé sur l'IPC et nommé formule Friedland. La CAT utilise maintenant le nouveau facteur (décrit ci-contre) pour indexer la plupart des indemnités, mais elle utilise encore l'IPC dans certains cas (voir le tableau en encart).



# Policy Report



Workers' Compensation Board

Commission des accidents du travail

August, 1995  
Vol. 8, No. 3

## Subsection 147(14)—Up to \$200 additional payment

On December 9, 1994, the Ontario legislature passed **Bill 165** which, among other things, adds subsection 147(14) to the *Workers' Compensation Act* (the *Act*). Effective January 1, 1995, this subsection directs the WCB to pay up to \$200 per month to workers who are receiving a permanent partial disability pension (or had their pension commuted to a lump sum), and who meet any of the following criteria:

- they are getting or are eligible for a 147(4) supplement
- they were eligible for a 147(4) supplement, but stopped getting it because they started to receive federal Old Age Security (OAS) benefits, or
- they would have been entitled to a 147(4) supplement except that on July 26, 1989\* they were already receiving OAS benefits. (The WCB sent questionnaires to these workers to help determine entitlement.)

**Not all workers are eligible for the full \$200 additional payment since benefits are calculated subject to the minimums and maximums set out in the *Act*.**

- 1) 75 per cent of pre-injury gross earnings for pre-1985 injuries (before April 1, 1985), or
- 2) 90 per cent of the pre-injury net average earnings (NAE) for post-1985 injuries (on or after April 1, 1985), subject to the minimums and maximums set out in the *Act*.

### For workers who aren't receiving OAS

For workers who are now receiving or are entitled to receive the 147(4) supplement and who are not receiving OAS benefits, the WCB is required to calculate the 147(14) additional payment first, and then recalculate the 147(4) supplement (see Example 1 on page 2).

### Eligibility for a 147(4) supplement

To fully understand how the WCB determines who is eligible for an additional payment, it is important to briefly review subsection 147(4) of the *Act*. This subsection directs the WCB to pay a supplement to workers who are receiving a permanent partial disability pension for an injury that occurred before January 2, 1990; have a wage loss at least partially due to the injury; and

- who are unlikely to benefit from vocational rehabilitation (VR), or
- whose earning capacity after VR is not increased to the extent that the sum of their pension and earning capacity approximates their pre-injury earnings.

If workers are receiving, or if it is determined they would have been eligible to receive, the 147(4) permanent supplement, the WCB can proceed with the 147(14) calculation.

### Calculations

Not all workers are eligible for the full \$200 additional payment since workers' benefits are calculated based on

#### Step 1: Subsection 147(14)

To determine how much of the \$200 a worker is entitled to, the WCB adds up the values of the worker's permanent disability pension; current earnings (if any) from employment at 75 per cent of gross, or 90 per cent of NAE; and any CPP/QPP benefit they are receiving for the injury (see examples).

If the total is **less** than

- 75 per cent of the worker's pre-injury gross income, or
  - 90 per cent of the worker's pre-injury NAE
- the WCB pays the difference up to the maximum of \$200 per month.

#### Step 2: Subsection 147(4)

To recalculate the 147(4) supplement, the WCB adds up the values of the workers' permanent disability pension; post-injury earnings, if any, from employment, at 75 per cent of gross or 90 per cent of NAE; **and** the 147(14) additional payment (calculated in *Step 1*).

If the total is **still** less than

- 75 per cent of the worker's pre-injury gross income, or
  - 90 per cent of the worker's pre-injury NAE
- the WCB adds on the 147(4) supplement, subject to statutory maximums.

*continued on page 2*

\* This is the date when Bill 162 was passed, directing the WCB to pay this supplement.

**Zero calculation**—If, after calculating the two benefits, the amount of the 147(4) supplement is zero dollars, workers are still entitled to all or part of the 147(14) additional payment.

#### **For workers receiving OAS benefits**

For workers who were getting OAS benefits on July 26, 1989, and therefore did not get a 147(4) supplement, the WCB must establish that they would have been eligible for the supplement, had they not been receiving OAS benefits.

*continued on page 3*

### **Example 1**

Jenny was a 53-year-old crane operator when she suffered a work-related injury in 1988 which left her with a permanent disability. Jenny received medical rehabilitation, but the WCB determined that she was not able to benefit from VR to the extent that the sum of her pension and earning capacity approximates her pre-injury earnings. In 1995, Jenny was receiving a permanent disability pension of \$955 per month. She was employed again doing office work and had NAE of \$1200 per month; and was receiving a 147(4) permanent supplement.

**Question:** Is Jenny eligible for any part of the \$200 additional payment under 147(14)?

To find out, the WCB indexed Jenny's pre-injury earnings on January 1 each year— 1989 through 1995— and then calculated the 147(14) additional payment, as though she was **not** receiving the 147(4) supplement.

<b>Key:</b>	NAE	=	monthly net average earnings	<b>Given:</b>	Pre-injury NAE	=	\$2408 (indexed to '95)
	OAS	=	Federal Old Age Security benefit		PDP	=	\$955
	PDP	=	monthly permanent disability pension		Current NAE	=	\$1200
					CPP/QPP*	=	\$0.0
					OAS	=	\$0.0

#### **Step 1 - Apply subsection 147(14) formula**

$$\begin{aligned}147(14) &= (90\% \text{ pre-injury NAE}) - [\text{PDP} + (90\% \text{ current NAE}) + \text{CPP/QPP}] \\&= (.90 \times \$2408) - [\$955 + (.90 \times \$1200) + \$0.0] \\&= \$2167.20 - (\$955 + \$1080) \\&= \$2167.20 - \$2035 \\&= \mathbf{\$132.20}\end{aligned}$$

The calculation establishes that Jenny is entitled to \$132.20 of the \$200 additional payment. The next question is whether Jenny is still eligible for the 147(4) permanent supplement.

#### **Step 2 - Apply subsection 147(4) formula**

$$\begin{aligned}147(4) &= (90\% \text{ pre-injury NAE}) - [\text{PDP} + (90\% \text{ current NAE}) + 147(14) \text{ additional payment}] \\&= (.90 \times \$2408) - [\$955 + (.90 \times \$1200) + \$132.20] \\&= \$2167.20 - [\$955 + \$1080 + \$132.20] \\&= \$2167.20 - \$2167.20 \\&= \mathbf{\$0.0}\end{aligned}$$

Jenny's entitlement to the 147(4) supplement is zero dollars. A zero 147(4) calculation does not preclude Jenny from receiving the 147(14) payment. The \$132.20 additional payment brings Jenny's post-injury income up to the statutory maximum of 90% of the pre-injury NAE. She will receive her payment of \$132.20 per month for life, unless there is a change in her financial circumstances. The WCB reviews payments routinely at 24- and 60-month intervals after the date of initial determination.

\* If a worker's pre-injury earnings are reduced by a CPP/QPP disability benefit in the 147(14) calculation, the reduction is not made in the 147(4) calculation.



The WCB establishes eligibility by confirming that the worker had a wage loss and that the wage loss was at least partially due to the injury. (If the worker received a 45(7) supplement under the pre-'89 Act, the WCB assumes that the worker would have been eligible.) Once the WCB determines that a worker would have been

eligible, it can proceed with the 147(14) calculation (see Example 2, below).

**Subsection 147(14) reviews**

The WCB pays the 147(14) additional payment for life, unless a worker's financial circumstances change.  
*continued on page 4*

**Example 2**

In 1984, when he was 63 years of age, Stefan had a work-related injury for which he was entitled to a permanent partial disability pension. Stefan did not enter a VR program. He did not receive a pre-'89 supplement, and he was already receiving his OAS pension when Bill 162 came into effect, so he didn't get a 147(4) supplement either.

**Question:** Is Stefan eligible for any part of the \$200 additional payment?

Before the WCB can do a 147(14) calculation, it must establish that there was a wage loss. Stefan's pre-injury earnings are indexed each January 1, from 1985 through 1989, before the wage-loss calculation is done.

<b>Key:</b>	GE = monthly gross earnings	<b>Given:</b>	PDP = \$506.25 (indexed to '89)
	OAS = Federal Old Age Security Benefit		PDP = \$602.69 (indexed to '95)
	PDP = monthly permanent disability pension		Current GE = \$0.0
			OAS = \$387.74
			CPP/QPP = \$0.0
<b>Given:</b>	Pre-injury GE = \$2250 (indexed to '89)		
	Pre-injury GE = \$2678.64 (indexed to '95)		

**Step 1 - Establish wage loss**

Wage loss = (75% pre-injury GE) - [PDP + (75% current monthly GE) + CPP/QPP]  
= (.75 x \$2250) - (\$506.25 + \$0.0 + \$0.0)  
= \$1687.50 - \$506.25  
= **\$1181.25**

Now that the wage loss is shown, the WCB must ensure that it was at least partially due to the injury.

**Step 2 - Establish if wage loss is due to injury**

Stefan's records show that the WCB did not offer him VR because he was temporarily totally disabled well into his 64th year. His age, skills, and the medical documentation in his file indicated that his wage loss was due to his injury. Now, the WCB calculates the 147(14) additional payment. Indexed up to 1995, the pre-injury earnings are \$2678.64, and the permanent disability pension is \$602.69 per month.

**Step 3 - Apply 147(14) formula**

147(14) = (75% pre-injury GE) - [PDP + (75% current GE) + OAS]  
= (.75 x \$2678.64) - (\$602.69 + \$0.0 + \$387.74)  
= \$2008.98 - \$990.43  
= \$1018.55  
= **\$200 (maximum)**

Stefan will receive the full \$200 additional payment per month, for life.

### ...reviews (continued)

To consider changes, the WCB may review the additional payment at any time, but routinely reviews it:

- 24 months and 60 months after the initial determination of the 147(4) permanent supplement
- when the 147(4) supplement is discontinued because the worker is eligible for OAS benefits, and
- if the amount of a worker's partial disability pension is adjusted.

### Multiple claims

Workers are entitled to only one 147(14) payment. If a worker has more than one claim, the additional payment is made in the oldest claim in which there is entitlement. But, if the amount of the payment that can be made in that claim is less than \$200, the balance is applied in the next oldest claim in which there is entitlement, and so on.

### Interaction with temporary benefits

If a 147(14) payment is made in a claim, and the worker becomes entitled to temporary disability benefits for a recurrence of the injury/disease, the WCB adjusts the temporary benefit to ensure that the **sum** of the

- temporary benefit
- permanent disability pension
- 147(4) supplement, and
- 147(14) payment

does not exceed 75 per cent of the pre-injury gross earnings or 90 per cent of pre-injury NAE.

If workers become entitled to temporary disability benefits in a new claim, or in a claim other than the one in which

they receive a 147(14), there is no effect on the 147(14) payment, nor does the payment affect the temporary benefit.

### Overpayments

The WCB sets up an overpayment if workers receive a 147(4) supplement to which they are not entitled. Any 147(14) benefits associated with that supplement become part of the overpayment.

### Commutation

The 147(14) payments cannot be commuted (i.e., paid in a lump sum).

For more information, watch for updates to the *Operational Policy* manual.

## -Policy Report-

Workers' Compensation Board  
Commission des accidents du travail

**Policy Report** is published under the authority and direction of the Benefits Policy Branch of the Workers' Compensation Board. If there is any conflict between the statements contained in this publication and the *Workers' Compensation Act* and/or WCB-approved policy documents, the Act, or the approved document, governs.

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## S.147(4) Supplement—Special Review Team

*On March 6, 1995, the Workers' Compensation Board (WCB) announced that it would use its powers under s.70 of the Workers' Compensation Act (the Act) to reconsider all decisions which resulted in the discontinuance of the s.147(4) supplement at the 60-month review. To accomplish this, the WCB established a special review team. This article is an update of the work undertaken by the team.*

In 1989, Bill 162 amended the Act. Section 147 (formerly s.135) of the amended Act required the WCB to pay supplements under certain circumstances to workers with permanent partial disabilities. Now, as then, s.147(4) supplements are paid to injured workers who cannot benefit from a vocational rehabilitation program, and whose post-injury earnings, plus their workers' compensation pension, do not approximate their pre-injury earnings.

This portion of Bill 162 became effective at Royal Assent in July, 1989, and the majority of s.147(4) supplements were approved in the period July to December, 1989.

### Supplement reviews

Under s.147(13), the WCB is required to recalculate a worker's supplement at 24 months and again at 60 months following the original supplement. The recalculation is based on the amount of the supplement, the worker's pension, and any post-injury earnings.

The 60-month review process began in July, 1994. At the same time as these reviews were taking place, there was considerable public discussion and debate regarding Bill 165 and the \$200 additional payment that was to be made to workers under s.147(14). These additional payments—which are tied directly to whether the injured worker is eligible to receive a s.147(4) supplement—caused concern that the WCB might terminate workers' supplements when they were reviewed, thus limiting the number of workers eligible for the new \$200 additional payment.

### Special review team

In response to this concern, the WCB carefully examined the entire issue. To ensure public confidence in the 60-month reviews, the WCB assembled a special review team, under the authority of s.70 of the Act, to review these decisions.

Upon careful review, the WCB concluded that the decisions to continue the supplements were sound, and that the team would focus on the approximately 3,000 decisions that resulted in a discontinuation of the s.147(4) supplement.

The WCB appointed 30 senior staff to the special review team. Letters were sent to the injured workers, their accident employers, and representatives, advising them of the special review. All parties were given the opportunity to forward written submissions.

The team focused on workers' actual earnings from their post-injury jobs, including any post-accident earnings the worker no longer had for reasons unrelated to the injury, and any CPP/QPP payments received as a result of the injury [s.147(11)]. Then, in accordance with s.147(9) and s.147(10), the team compared the worker's pre-injury earnings to the post-injury income to determine eligibility for the supplement.

The team completed its reviews on the target date of June 30, 1995. While cases were being reviewed by the special review team, the 60-month decision stood. If the team reversed the 60-month review decision, the worker received a payment retroactive to the date of the earlier decision.

### Right of appeal

If the special review team upheld the earlier 60-month decision to discontinue the s.147(4) supplement, and if injured workers wish to appeal, they must complete and send an application for mediation to the WCB. If the original decision is overturned (i.e., the supplement is allowed), the employer has the right to apply for mediation services. Once an application is received, a mediator is assigned to the case.

For more information on s.147(4) and s.147(14), refer to the article and examples in this issue of *Policy Report*.



Workers'  
Compensation  
Board

Commission  
des accidents  
du travail

## Supplément prévu au par. 147 (4)—Équipe de révision spéciale

Après avoir examiné attentivement les dossiers en cause, la CAT a conclu que les décisions selon lesquelles le supplément continuait d'être versé étaient justes et que l'équipe se concentrerait donc sur les quelque 3 000 décisions qui avaient occasionné la cessation du versement du supplément.

La CAT a désigné 30 membres de son personnel de niveau supérieur pour faire partie de l'équipe de révision spéciale. La CAT a envoyé des lettres aux travailleurs blessés, à l'employeur qu'ils avaient au moment de l'accident et aux représentants pour les informer qu'une révision spéciale allait avoir lieu. Toutes les parties ont eu l'occasion de faire parvenir à la CAT des observations écrites.

Lors de la révision, l'équipe a tenu compte des gains réels tirés d'emplois que le travailleur a occupés après la lésion, y compris les gains qu'il a cessé de recevoir pour des raisons non liées à la lésion [par. 147 (11) de la Loi]. Conformément aux paragraphes 147 (9) et (10), l'équipe a ensuite comparé les gains que le travailleur a touchés avant la lésion aux revenus qu'il a gagnés après la lésion pour déterminer s'il était admissible au supplément.

L'équipe a terminé la révision de ce supplément à la date prévue, soit le 30 juin 1995. Les décisions rendues au 60<sup>e</sup> mois ont été maintenues pendant que l'équipe de révision spéciale les réexaminait. Si l'équipe annulait une décision, le travailleur avait droit à un paiement rétroactif à la date de la révision qui avait eu lieu au 60<sup>e</sup> mois.

### Droit de contestation

Dans le cas où la décision de cesser le versement du supplément prévu au par. 147 (4) a été maintenue par l'équipe de révision spéciale, le travailleur blessé peut déposer une contestation; il doit alors remplir et envoyer à la CAT un formulaire de contestation sur lequel il indique qu'il s'engage dans le processus de médiation. Si la décision a été annulée et que le supplément est accordé, l'employeur a le droit de contester la décision et de demander des services de médiation. Une fois que la CAT a reçu le formulaire de contestation, elle désigne un médiateur.

Pour obtenir de plus amples renseignements sur le supplément prévu au paragraphe 147 (4) et le montant additionnel prévu au paragraphe 147 (14), reportez-vous à l'article et aux exemples qui figurent dans le présent *Bulletin des politiques*.

Le 6 mars 1995 la Commission des accidents du travail (CAT) a annoncé qu'elle aurait recours au pouvoir que lui confère l'article 70 de la Loi sur les accidents du travail pour réexaminer toutes les décisions qui, au moment de la révision prévue au 60<sup>e</sup> mois, ont occasionné la cessation des versements du supplément prévu au par. 147 (4). Pour ce faire, la CAT a mis sur pied une équipe de révision spéciale.

En 1989, la Loi 162 modifiait la Loi sur les accidents du travail (la Loi) et prévoyait à l'article 147 (article 135 de la Loi d'avant 1989) que la CAT verserait un supplément à certains travailleurs ayant une invalidité partielle permanente. Ainsi, le supplément prévu au par. 147 (4) est versé aux travailleurs blessés qui ne bénéficieraient vraisemblablement pas de services de réadaptation professionnelle, et dont la somme des gains d'après la lésion et de la pension d'invalidité versée par la CAT ne correspond pas approximativement aux gains qu'ils touchaient avant la lésion.

Cette disposition de la Loi 162 a été mise en application au moment où le projet de loi a reçu la sanction royale, en juillet 1989; la majorité des suppléments versés aux termes du par. 147 (4) ont été accordés entre juillet et décembre 1989.

### Révisions du supplément

Aux termes du par. 147 (13), la CAT est tenue de recalculer le supplément prévu au par. 147 (4) pendant le vingt-quatrième mois et le soixantième mois après son octroi. Lorsqu'elle recalcule le supplément, la CAT tient compte du montant du supplément du travailleur, de la pension de celui-ci et des gains moyens d'après la lésion, le cas échéant.

Les premières révisions au 60<sup>e</sup> mois ont été effectuées en juillet 1994. À cette époque, un important débat public prenait place au sujet du *Projet de loi 165* et du montant additionnel de 200 \$ prévu au par. 147 (14), qui devait être versé à certains travailleurs à compter du 1<sup>er</sup> janvier 1995. Comme ce montant additionnel est directement lié au fait que le travailleur blessé soit admissible au supplément prévu au par. 147 (4), les personnes et groupes intéressés craignaient que la CAT cesse le versement du supplément au moment de la révision, limitant ainsi le nombre de travailleurs qui seraient admissibles au nouveau montant additionnel de 200 \$.

### Équipe de révision spéciale

Par suite des préoccupations exprimées, la CAT a soigneusement examiné la question ayant soulevé ce débat et a pris des mesures pour rassurer le public relativement à la révision au 60<sup>e</sup> mois. En vertu du pouvoir que lui confère l'article 70 de la Loi, la CAT a mis en place une équipe de révision spéciale chargée de réexaminer toutes les décisions relatives au supplément prévu au par. 147 (4) rendues au 60<sup>e</sup> mois.





Afin de tenir compte de ces changements, la CAT peut réviser le montant additionnel en tout temps, mais elle effectue une révision systématique :

- au 60<sup>e</sup> mois suivant la détermination initiale du supplément permanent prévu au par. 147 (4) ;
- lorsque le supplément prévu au par. 147 (4) cesse d'être versé parce que le travailleur devient admissible à la pension de SV ;
- si le montant de la pension d'invalidité partielle permanente est rajusté.

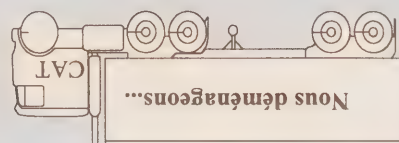
#### Plus d'un dossier pour le même travailleur

Un travailleur a droit à un seul montant additionnel prévu au par. 147 (14). S'il existe plus d'un dossier pour le même travailleur, le montant additionnel est versé en fonction du plus ancien dossier dans le cadre duquel il y est admissible. Si le montant accordé dans le cadre de ce dossier n'est qu'une portion du 200 \$, la différence entre cette portion et le montant intégral de 200 \$ sera traitée en fonction du deuxième plus ancien dossier dans le cadre duquel le travailleur est admissible au montant additionnel, et ainsi de suite.

#### Interaction avec des indemnités d'invalidité temporaire

Si un montant est versé au travailleur en vertu du par. 147 (14) et que, dans le cadre du même dossier, le travailleur devient admissible à des indemnités d'invalidité temporaire par suite d'une récidence, la CAT rajuste ces indemnités de sorte que la somme des indemnités d'invalidité temporaire, de la pension d'invalidité permanente, du supplément prévu au par. 147 (4) et du montant additionnel prévu au par. 147 (14) ne dépasse pas 75 % des gains bruts ou 90 % des GMN d'avant la lésion.

Si le travailleur devient admissible à des indemnités d'invalidité temporaire dans le cadre d'un nouveau dossier, ou d'un dossier



#### Unités de services intégrés

À compter du (1995)

USI 4 - Construction  
USI 8 - Toronto-Sud  
USI 6 - Toronto-Ouest  
USI 7 - Centre-Sud de l'Ontario  
USI 3 - Toronto-Nord  
USI 5 - Centre-Ouest de l'Ontario  
USI 0 - Unité des dossiers complexes (maladies)  
USI Z - Unité des dossiers complexes (lésions)  
USI 2 - Toronto-Est  
USI 1 - Centre-Est de l'Ontario

17 juillet  
24 juillet  
24 juillet  
31 juillet  
8 août  
8 août  
14 août  
14 août  
28 août  
5 septembre

#### Numéros locaux

(416) 344-1004  
(416) 344-1008  
(416) 344-1006  
(416) 344-1007  
(416) 344-1003  
(416) 344-1005  
(416) 344-1010  
(416) 344-1009  
(416) 344-1002  
(416) 344-1001

#### Numéros sans frais

1-800-387-0080  
1-800-387-0064  
1-800-387-0062  
1-800-387-0068  
1-800-387-8607  
1-800-387-0025  
1-800-465-9646  
1-800-465-5538  
1-800-387-0066  
1-800-263-8877

au : 200, rue Front Ouest  
Toronto ON M5V 3J1

**Bulletin des politiques**  
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Veuillez adresser vos questions ou commentaires à la :

Le **Bulletin des politiques** est publié par la Direction des politiques sur l'indemnisation de la Commission des accidents du travail. S'il y a contradiction entre le texte de la présente publication et la Loi sur les accidents du travail et/ou les politiques approuvées de la Commission, c'est à la Loi ou aux documents approuvés qu'il faut se référer.



**Bulletin des politiques**  
Workers' Compensation Board  
Commission des accidents du travail

#### Manuel des politiques opérationnelles

Pour obtenir plus de renseignements, suivez les mises à jour du

#### Capitalisation

Le montant additionnel prévu au par. 147 (14) ne peut pas être capitalisé c.-à-d. versé sous forme de paiement global.

#### Paiements excédentaires

Un paiement excédentaire se produit lorsque la CAT verse le supplément prévu au par. 147 (4) à un travailleur qui en réalité n'y a pas droit. Tout montant additionnel prévu au par. 147 (14) lié à ce supplément est partie intégrante du paiement excédentaire.

autre que celui dans le cadre duquel il reçoit le montant additionnel prévu au par. 147 (14), les indemnités d'invalidité temporaire n'ont pas d'incidence sur le montant additionnel, et vice versa.

La CAT établit l'admissibilité au supplément en confirmant que le travailleur subissait une perte de salaire et que celle-ci était due au moins en partie à la lésion. (Si le travailleur recevait le supplément prévu au par. 45 (7) de la Loi d'avant 1989, la CAT tient pour acquis que le travailleur aurait été admissible au supplément aux termes du par. 147 (4).) Une fois que la CAT a déterminé l'admissibilité, elle peut procéder au calcul du montant additionnel prévu au par. 147 (14) (voir l'Exemple 2 ci-dessous).

## Exemple 2

En 1984, Stéphane était âgé de 63 ans lorsqu'il a subi une lésion reliée au travail pour laquelle il a eu droit à une pension d'invalidité partielle permanente. Stéphane n'a pas participé à un programme de réadaptation professionnelle. Il n'a pas reçu le supplément prévu par la Loi d'avant 1989 et il recevait déjà une pension de SV lorsque la Loi 162 est entrée en vigueur. Il n'a pas eu droit au supplément prévu au par. 147 (4) non plus.

Question : Stéphane a-t-il droit en tout ou en partie au montant additionnel de 200 \$ prévu au par. 147 (14)?

Avant de pouvoir effectuer le calcul du montant additionnel prévu au par. 147 (14), la CAT doit d'abord déterminer si Stéphane a subi une perte de salaire. La CAT a indexé les gains d'avant la lésion de Stéphane le 1<sup>er</sup> janvier de chaque année, de 1985 à 1989, avant de calculer la perte de salaire.

### Légende :

GB	=	gains bruts mensuels
PIP	=	pension d'invalidité permanente mensuelle
SV	=	pension de SV mensuelle
RPC	=	Régime de pensions du Canada
RRQ	=	Régime de rentes du Québec
GB d'avant la lésion = 2 250,00 \$ (indexés au 1 <sup>er</sup> janv. 1989)		
GB d'avant la lésion = 2 678,64 \$ (indexés au 1 <sup>er</sup> janv. 1995)		
PIP	=	506,25 \$ (indexés au 1 <sup>er</sup> janv. 1989)
PIP	=	602,69 \$ (indexés au 1 <sup>er</sup> janv. 1995)
GB actuels	=	0,00 \$
SV	=	387,74 \$
RPC/RRQ	=	0,00 \$

### Données :

$$\begin{aligned} \text{Perte de salaire} &= (75 \% \text{ des GB d'av. la lésion}) - [\text{PIP} + (75 \% \text{ des GB actuels}) + \text{RPC/RRQ}] \\ &= (0,75 \times 2\,250,00 \$) - [506,25 \$ + (0,75 \times 0,00 \$) + 0,00 \$] \\ &= 1\,687,50 \$ - 506,25 \$ \\ &= 1\,181,25 \$ \end{aligned}$$

Maintenant que la CAT a établi que Stéphane a subi une perte de salaire, elle doit s'assurer que celle-ci est au moins en partie due à la lésion.

## Étape 2 - La perte de salaire découlait-elle de la lésion?

Le dossier de Stéphane révèle que la CAT ne lui a pas offert de services de réadaptation professionnelle parce qu'il avait une invalidité totale temporaire au moment où il approchait l'âge de 65 ans. Les renseignements contenus dans son dossier (âge, aptitudes et rapports médicaux) ont permis de confirmer que la perte de salaire était due à la lésion. La CAT peut maintenant calculer le montant additionnel prévu au par. 147 (14). Les gains que Stéphane avait avant la lésion, indexés au 1<sup>er</sup> janvier 1995, sont de 2 678,64 \$, et sa pension d'invalidité permanente est de 602,69 \$ par mois.

## Étape 3 - Calcul du montant additionnel prévu au par. 147 (14)

$$\begin{aligned} 147 (14) &= (75 \% \text{ des GB d'av. la lésion}) - [\text{PIP} + (75 \% \text{ des GB actuels}) + \text{SV}] \\ &= (0,75 \times 2\,678,64 \$) - [602,69 \$ + (0,75 \times 0,00 \$) + 387,74 \$] \\ &= 2\,008,98 \$ - 990,43 \$ \\ &= 1\,018,55 \$ \\ &= 200 \$ (\text{maximum}) \end{aligned}$$

Stéphane a droit au montant additionnel intégral de 200 \$ par mois, à vie.

## Révisions du montant additionnel prévu au par. 147 (14)

Le montant additionnel prévu au par. 147 (14) est versé à vie, à moins que des changements ne surviennent dans la situation financière du travailleur.

(Suite à la page 4)



### Exemple 1

**Lorsque le montant du supplément est de zéro dollars**  
Si, après avoir calculé le supplément et le montant additionnel, le montant du supplément prévu au par. 147 (4) est de zéro dollars, le travailleur a quand même droit au montant additionnel prévu au par. 147 (14) ou à une partie de celui-ci.

reçu de pension de SV.

**Lorsque le travailleur reçoit une pension de SV**  
Si le travailleur recevait une pension de SV le 26 juillet 1989, et ne recevait donc pas le supplément prévu au par. 147 (4), la CAT doit établir s'il aurait eu droit à ce supplément s'il n'avait alors pas

Question : Jenny a-t-elle droit en tout ou en partie au montant additionnel de 200 \$ prévu au par. 147 (14)?  
Pour déterminer si Jenny a droit au montant additionnel, la CAT a indexé ses gains d'avant la lésion le 1<sup>er</sup> janvier de chaque année, de 1989 à 1995, puis a calculé le montant additionnel prévu au par. 147 (14), comme si la travailleuse ne recevait pas le supplément prévu au par. 147 (4).

#### Légende :

#### Données :

GMN	=	gains moyens nets mensuels	GMN d'avant la lésion	=	2 408,00 \$ (indexés au 1 <sup>er</sup> janv. 1995)
PIP	=	pension d'invalidité permanente mensuelle	PIP	=	955,00 \$
SV	=	pension de SV mensuelle	GMN actuels	=	1 200,00 \$
RPC	=	Régime de pensions du Canada	RPC/RPQ*	=	0,00 \$
RRQ	=	Régime de rentes du Québec	SV	=	0,00 \$

$$\begin{aligned}
 \text{Étape 1 - Calcul du montant additionnel prévu au par. 147 (14)} \\
 &= (90\% \text{ des GMN d'av. la lésion}) - [\text{PIP} + (90\% \text{ des GMN actuels}) + \text{RPC/RRQ}] \\
 &= (0,90 \times 2\,408,00 \$) - [955,00 \$ + (0,90 \times 1\,200,00 \$) + 0,00 \$] \\
 &= 2\,167,20 \$ - 2\,035,00 \$ \\
 &= 132,20 \$
 \end{aligned}$$

Le calcul permet d'établir que Jenny a droit à 132,20 \$ du montant additionnel de 200 \$. Il s'agit maintenant de déterminer si Jenny a toujours droit au supplément permanent prévu au par. 147 (4).

#### Étape 2 - Calcul du supplément prévu au par. 147 (4)

$$\begin{aligned}
 &= (90\% \text{ des GMN d'av. la lésion}) - [\text{PIP} + (90\% \text{ des GMN actuels}) + \text{le montant additionnel prévu au par. 147 (14)}] \\
 &= (0,90 \times 2\,408,00 \$) - [955,00 \$ + (0,90 \times 1\,200,00 \$) + 132,20 \$] \\
 &= 2\,167,20 \$ - (955,00 \$ + 1\,080,00 \$ + 132,20 \$) \\
 &= 2\,167,20 \$ - 2\,167,20 \$ \\
 &= 0,00 \$
 \end{aligned}$$

Le fait que le résultat du calcul du supplément prévu au par. 147 (4) est de zéro n'enlève pas le droit à Jenny de recevoir le montant prévu au par. 147 (14). Le montant additionnel de 132,20 \$ porte ses revenus d'après la lésion au maximum prévu par la Loi, soit 90 % de ses GMN d'avant la lésion. Ce montant additionnel lui sera versé à vie, à moins que sa situation financière ne change. La CAT révisera systématiquement le montant additionnel au 24<sup>e</sup> mois et au 60<sup>e</sup> mois suivant la date de la détermination initiale.

\* Les gains d'avant l'accident du travailleur sont réduits en raison de prestations d'invalidité versées au titre du RPC/RRQ au cours du calcul du montant additionnel prévu au par. 147 (14), mais pas au cours du calcul du supplément prévu au par. 147 (4).



## -e paragraphe 147 (14)—Montant additionnel pouvant atteindre 200 \$

Le 9 décembre 1994, l'Assemblée législative de l'Ontario a adopté le **Projet de loi 165** qui, entre autres, ajoute le paragraphe 147 (14) à la *Loi sur les accidents du travail* (la *Loi*). Mis en application le 1<sup>er</sup> janvier 1995, ce paragraphe oblige la Commission des accidents du travail (CAT) à payer un montant additionnel pouvant atteindre 200 \$ par mois aux travailleurs qui reçoivent une pension d'invalidité partielle permanente (ou qui ont reçu celle-ci sous forme de paiement global), et qui respectent un des critères suivants :

ils reçoivent le supplément prévu au par. 147 (4) ou y sont admissibles;

ils avaient droit au supplément prévu au

par. 147 (4), mais ont cessé de le recevoir

parce qu'ils ont commencé à recevoir une

pension de sécurité de la vieillesse (SV) du

gouvernement fédéral;

ils auraient eu droit au supplément prévu au

par. 147 (4), mais, en date du 26 juillet 1989\*,

ils recevaient déjà une pension de SV. (La

CAT a envoyé un questionnaire à ce dernier

détermination de l'admissibilité.)

## Admissibilité au supplément prévu au par. 147 (4)

Afin de comprendre tout à fait comment la CAT détermine si un

travailleur a droit au montant additionnel prévu au par. 147 (14)

de la *Loi*, il est important de donner les grandes lignes du

par. 147 (4). Ce paragraphe oblige la CAT à verser un supplément

aux travailleurs qui reçoivent une pension d'invalidité partielle

permanente pour une lésion survenue avant le 2 janvier 1990,

subissent une perte de salaire due au moins en partie à cette

lésion et :

ne profiteront vraisemblablement pas d'un programme de

réadaptation professionnelle, ou

au terme d'un programme de réadaptation professionnelle, ne

verront pas leur capacité de gain augmenter au point que la

somme de celle-ci et de leur pension corresponde

approximativement à leurs gains d'avant la lésion.

Si le travailleur reçoit le supplément permanent prévu au

par. 147 (4), ou s'il est déterminé qu'il y aurait été admissible, la

CAT peut alors effectuer le calcul du montant prévu au

par. 147 (14).

## Calculs

Certains travailleurs n'ont pas droit au montant additionnel

\* Il s'agit de la date d'adoption du Projet de loi 162, en vertu duquel la CAT doit verser ce supplément.

intégral de 200 \$, étant donné que les indemnités versées par la CAT sont calculées en fonction de :

1) 75 % des gains bruts d'avant la lésion, dans le cas des lésions survenues avant 1985 (avant le 1<sup>er</sup> avril 1985);

2) 90 % des gains moyens nets (GMN) d'avant la lésion, dans le cas des lésions survenues après 1985 (le 1<sup>er</sup> avril 1985 ou après cette date),

sous réserve des montants minimums et maximums prévus par la *Loi*.

## Lorsque le travailleur ne reçoit pas de pension de SV

Certains travailleurs n'ont pas droit au montant additionnel intégral de 200 \$, étant donné que les indemnités versées par la CAT sont calculées en fonction des montants minimums et maximums prévus par la *Loi*.

## Étape 1 : montant additionnel prévu au par. 147 (14)

Pour déterminer la portion du 200 \$ à laquelle le travailleur a droit, la CAT fait la somme de la pension d'invalidité permanente du travailleur, de 75 % des gains bruts ou de 90 % des GMN qu'il tire actuellement d'un emploi (le cas échéant) et de toute prestation qu'il reçoit au titre du RPC/RRQ pour la lésion (voir les exemples).

Si le total est inférieur à

• 75 % des gains bruts du travailleur avant la lésion, ou

• 90 % des GMN du travailleur avant la lésion,

la CAT paie la différence jusqu'à un maximum de 200 \$ par mois.

## Étape 2 : supplément prévu au par. 147 (4)

Pour recalculer le supplément prévu au par. 147 (4), la CAT fait la somme de la pension d'invalidité permanente du travailleur, de 75 % des gains bruts ou de 90 % des GMN qu'il tire actuellement d'un emploi (le cas échéant) et du montant additionnel prévu au par. 147 (14) (calculé à l'Étape 1).

Si le total est toujours inférieur à

• 75 % des gains bruts du travailleur avant la lésion, ou

• 90 % des GMN du travailleur avant la lésion,

la CAT verse le supplément prévu au par. 147 (4), sous réserve des maximums prévus par la *Loi*.



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# Policy Report



Workers'  
Compensation  
Board

Commission  
des accidents  
du travail

December, 1995  
Vol. 8, No. 4

## WCB gets tough on fraud

Fraud is a problem that has plagued the insurance industry for decades and there is no indication that the problem has abated, despite measures to combat it.

Workers' compensation boards across Canada—perceived to be very much a part of the insurance industry—have their unique problems and are continually developing measures to eradicate fraud from the system.

Faced with its own experiences of fraudulent activities of the past few years, the Ontario WCB assembled representatives from its key operating areas to develop a comprehensive strategy to deal with fraud. Arising from that initiative, the Special Investigations Branch (SIB) was established in 1993, with a mandate to "...co-ordinate the WCB's response to fraud-related allegations and take appropriate measures to create the maximum deterrence to the fraudulent manipulation of services provided by the WCB."

To support the work of the SIB, and decision-makers, on November 1, 1995, the WCB approved four operational policies and guidelines. These policies have been published in the *Operational Policy* (OP) manual under the titles: *General Fraud* (01-03-01), *Fraud Involving Suppliers of Goods and Services* (01-03-02), *Worker Fraud* (01-03-03) and, *Employer Fraud* (01-03-04).

This issue of *Policy Report* presents an overview of the **General Fraud** policy which sets out, broadly, the goals of the fraud strategy and establishes a framework for the WCB's response when fraud is suspected.

The General Fraud policy states that the WCB cannot afford and will not tolerate fraud against the system by external suppliers of goods, workers and their dependants, or employers.

The WCB will aggressively protect the system against fraud by establishing effective internal controls and increasing WCB employees' knowledge and awareness detect fraud early in the process

- investigate and process all cases of suspected fraud fairly, diligently, and consistently
- stop the fraudulent outflow of funds and assets
- recover WCB assets when fraud occurs, while protecting the rights of individuals or companies suspected of fraud, in accordance with the *Freedom of Information and Protection of Privacy Act* (FIPPA).

### Definition of fraud

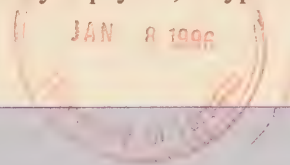
The WCB defines fraud as any wrongdoing or dishonest act that results in a real or potential loss to the WCB.

### Wrongdoings or dishonest acts include

- using a false document (birth certificate, S.I.N., WCB Certificate of Clearance)
- knowingly billing the WCB for services not provided to an injured worker
- working while claiming total disability benefits
- intentionally reporting lower than realistic payroll figures in order to pay less in assessments.

**If fraud is suspected**, WCB staff handling the file must immediately report the matter to a manager and, in consultation with the manager, arrange a preliminary investigation.

A **preliminary investigation** is the same as would occur in the ordinary course of business at the WCB. The investigation focuses on gathering pertinent information necessary to making the usual operational decisions such as: proof of accident, validity of payroll, or types of business operations.



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Integrated Service Unit phone numbers.....	page 4

### Action following preliminary investigation

When an investigation shows evidence of wrongdoing, the operating area, in consultation with the SIB, decides on the action to take. If no evidence of wrongdoing is found, it's business as usual!

### Referral to SIB

When alleged wrongdoing is confirmed, the operating area immediately prepares and sends a detailed referral memo to the SIB, along with the file.

### SIB review and investigation

The SIB reviews all cases of suspected fraud referred to it and, when warranted, conducts an investigation. When the review is completed, the SIB sends a report of its findings to the operating area, along with recommended courses of action.

In conducting the investigation, the SIB is allowed access to all files and documentation; this includes access to audio and visual recordings, but not limited to video tapes, tape recordings, and computer files.

### Response

When there is persuasive evidence of fraud, the WCB has the authority to take administrative actions, among them—settling the matter, levying a penalty, or creating an overpayment.

The WCB's Legal Branch may start a civil action for the recovery of monies or property. It may also recommend that criminal action be taken.

### Laying charges

If an offence is committed under the *Workers Compensation Act*, the Legal Branch lays formal charges under the *Provincial Offences Act*.

The police alone decide whether to lay charges under the *Criminal Code*.

### Confidentiality and access to information

The WCB treats all information concerning fraudulent activities as confidential. Workers, employers, or their representatives do not have access to files when an investigation is underway.

The WCB processes requests for access only when the operating areas' investigation is complete, and a decision is made.

### Objection

An individual under investigation can proceed with filing an objection against the WCB. However, the WCB may delay making a decision until the investigation has ended and the SIB makes its recommendation.

These fraud policies and guidelines apply to all incidents of suspected fraud discovered on or after November 1, 1995. For more information, please refer to your OP manual.

#### Note:

*On November 1, 1995, the government of Ontario introduced legislation to amend the Workers' Compensation Act as it pertains to fraud in the workers' compensation system. When this legislation is passed, some changes may be required to operational policies. These changes will be reported in another issue of Policy Report.*

## Post-judgement interest rates

The WCB pays interest on delayed benefits at the post-judgement interest rate set quarterly under the *Courts of Justice Act*. This interest rate is the official bank rate rounded up to the next higher whole number, plus one per cent.

The post-judgement rates are published in the *Ontario Gazette*.

	Quarter			
	1st	2nd	3rd	4th
1990	14%	15%	15%	14%
1991	14%	11%	11%	10%
1992	9%	9%	8%	7%
1993	10%	8%	7%	6%
1994	6%	6%	8%	7%
1995	8%	10%	9%	8%



# Indexing FEL benefits

As described in the May 1995 issue of *Policy Report*, Bill 165 introduced, as of January 1, 1995, a new indexing factor—referred to as the Friedland factor—and new rules for indexing FEL benefits [sections 43(4), 43(5), 43(6.1) of the *Act*].

In a nutshell, the WCB continues to index pre-injury average earnings by the Consumer Price Index (CPI) before calculating or reviewing all FEL benefits. The WCB applies the new indexing rules when calculating less-than-100% FEL benefits at the initial benefit calculation and at benefit reviews. The WCB continues to index all 100% FEL benefits by CPI on each January 1. The WCB indexes all less-than-100% FEL benefits by the Friedland factor on each January 1.

To demonstrate how the Friedland factor and the new indexing rules affect FEL benefits, this issue of *Policy Report* presents a FEL calculation which, for purposes of comparison, splits off to show the differences between a worker with and without the capacity to earn following the injury. First, the basic steps.

## 1. Index pre-injury gross earnings

The WCB brings the worker's pre-injury gross earnings up-to-date by applying the CPI for each January 1, since the injury.

## 2. Convert pre-injury gross earnings to net average earnings (NAE)

The probable income tax, Canada Pension Plan contributions (CPP), and unemployment insurance premiums payable by the worker, are deducted from the worker's gross earnings. To simplify the task, every January 1, the WCB creates a conversion table—the *Net Average Earnings Table*. To use the table, the WCB must have the worker's current net exemption code (NEC).

## 3. Convert post-injury gross earnings to NAE

The WCB converts the worker's current gross employment earnings, and/or any earnings the worker is likely to earn in suitable and available employment, to net average earnings. (See 07-02-08.)

## 4. Apply FEL formula

$$\text{FEL} = (\text{pre-injury NAE} - \text{post-injury NAE}) \times 90\%$$

Workers whose post-injury earnings are zero and who will not have the capacity to earn, receive a 100% FEL benefit. For them, the initial FEL calculation ends here. Go to step 6 for indexing on January 1.

Workers with post-injury earnings or earnings capacity receive a less-than-100% FEL benefit. Continue the calculation with steps 5 and 6.

## 5. Apply new indexing rule for workers with post-injury earnings or earnings capacity

The WCB adjusts the result of the FEL formula (step 4) by

- multiplying it, for each January 1 since the injury, by the sum of one plus the Friedland indexing factor  $1 + (75\% \times \text{CPI}) - 1\%$ , and
- dividing it, for each January 1 since the injury, by the sum of one plus CPI  $(1 + \text{CPI})$ .

Expressed as a fraction, this calculation (for one year) is

$$\text{Adjusted FEL} = \text{FEL} \times \frac{1 + [(75\% \times \text{CPI}) - 1\%]}{1 + \text{CPI}}$$

Note: This indexing adjustment is also applied at each FEL review as indicated below.

## 6. Index FEL benefit between reviews

Every January 1, following D1, the WCB indexes FEL benefits as follows:

- 100% FEL benefits by CPI
- less-than-100% FEL benefits by 75% of CPI - 1%.

## Recalculate FEL at R1 & R2 reviews

FEL benefits are recalculated

- 24 months (R1) after the initial FEL calculation (D1)
- 60 months (R2) after D1 and
- at any review due to a deterioration of the worker's condition which results in an increased Non-Economic Loss (NEL) benefit.

At reviews, the WCB applies the FEL formula (step 4) using the worker's pre-injury earnings (indexed by CPI) and current earnings. For workers with post-injury earnings or earnings capacity, the WCB also applies the new indexing rules (step 5).

### Compare FEL review amount to current FEL

After recalculating the FEL amount at any review, the WCB compares the new amount to that which the worker is currently receiving. If the difference between the two amounts is an increase/decrease of 10% or more, the worker receives the new amount. If the difference is less than a 10% increase/decrease, the worker continues to receive the current FEL amount. This calculation is

$$\% \text{ variance} = \frac{\text{current FEL} - \text{review FEL}}{\text{current FEL}} \times 100$$

### Index FEL benefits each year after the final review

Every January 1 following the final FEL review, the WCB indexes FEL benefits in the same way as it does between reviews

- 100% FELs by CPI
- less-than-100% FELs by 75% of CPI - 1%.

### Example (Insert)

Since the FEL calculations in our example (insert) deal with FEL reviews into the future, we have used a fictitious CPI for 1996, 1997, and 1998. Because the Friedland indexing factor is based on CPI, this factor for these years is also fictitious. As well, because the *Net Average Earnings Table* is not available for 1996 and 1998, the calculation uses the 1995 table to convert gross earnings to net earnings.

## Season's Greetings

## Policy Report

Workers' Compensation Board  
Commission des accidents du travail

**Policy Report** is published under the authority and direction of the Benefits Policy Branch of the Workers' Compensation Board. If there is any conflict between the statements contained in this publication and the *Workers' Compensation Act* and/or Board-approved policy documents, the *Act* or the approved document governs.

### Comments or inquiries should be addressed to:

Editor

#### Policy Report

Benefits Policy Branch  
Workers' Compensation Board  
200 Front Street West, 18th Floor  
Toronto, Ontario M5V 3J1



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## Notice

### The WCB has moved

from: 2 Bloor Street East, Toronto  
Ontario, M4W 3C3



to: 200 Front Street West,  
Toronto, Ontario, M5V 3J1

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(800)465-9646



R1 - May 5, '98	A - anticipated post-injury earnings = \$0	B - anticipated post-injury earnings = \$225 per week*
<b>6. Index FEL benefit between D1 &amp; R1</b> • 100% FELs by CPI • less-than-100% FELs by Friedland	FEL = \$1499.81 mo. $\$1499.81 \times 1.02$ (CPI Jan. '97) = \$1529.81/mo. $\$1529.81 \times 1.03$ (CPI Jan. '98) = \$1575.70/mo.	FEL = \$815.88 mo. $\$815.88 \times 1.005$ (F. Jan. '97) = \$819.96/mo. $\$819.96 \times 1.0125$ (F. Jan. '98) = \$830.21/mo.
<b>7. Index weekly pre-injury gross earnings by CPI for each Jan. 1, since the injury</b>	$\$500 \times 1.02$ (CPI Jan. '96) = \$510/wk. $\$510 \times 1.02$ (CPI Jan. '97) = \$520.20/wk. $\$520.20 \times 1.03$ (CPI Jan. '98) = \$535.81/wk.	$\$500 \times 1.02$ (CPI Jan. '96) = \$510/wk. $\$510 \times 1.02$ (CPI Jan. '97) = \$520.20/wk. $\$520.20 \times 1.03$ (CPI Jan. '98) = \$535.81/wk.
<b>8. Convert weekly indexed pre-injury gross earnings to monthly NAE using NAE Table &amp; NEC 01</b>	Pre-injury NAE = \$401.68/wk. = \$401.68 x 4.3333 wk. = \$1740.60/mo.	Pre-injury NAE = \$401.68/wk. = \$401.68 x 4.3333 wk. = \$1740.60/mo.
<b>9. Convert weekly post-injury gross earnings to monthly NAE using NAE Table &amp; NEC 01</b>	Post-injury NAE = \$0	Post-injury NAE = \$189.37/wk. = \$189.37 x 4.3333 wk. = \$820.60/mo.
<b>10. Apply FEL formula</b>  $\text{FEL} = \left( \frac{\text{pre-injury NAE} - \text{post-injury NAE}}{\text{pre-injury NAE}} \right) \times 90\%$	$\text{FEL} = (\$1740.60 - \$0) \times .90$ = \$1566.54/mo.  <b>Go to step 12</b> to compare FEL review amount to current FEL.	$\text{FEL} = (\$1740.60 - \$820.60) \times .90$ = \$828.00/mo.  As at D1 the calculation continues for workers with post-injury earnings. <b>Go to step 11.</b>
<b>11. Apply new indexing rule for each January 1 since the injury for workers with post-injury earnings capacity</b>  $\text{Review FEL} = \text{FEL} \times \frac{1 + [(75\% \times \text{CPI}) - 1\%]}{1 + \text{CPI}}$	<b>B</b>  $\text{Review FEL} = \text{FEL} \times \frac{1 + '96 \text{ Friedland}}{1 + '96 \text{ CPI}} \times \frac{1 + '97 \text{ Friedland}}{1 + '97 \text{ CPI}} \times \frac{1 + '98 \text{ Friedland}}{1 + '98 \text{ CPI}}$  $= \$828.00 \times \frac{1 + .5\%}{1 + 2\%} \times \frac{1 + .5\%}{1 + 2\%} \times \frac{1 + 1.25\%}{1 + 3\%}$  $= \$828.00 \times .9853 \times .9853 \times .983$  Review FEL = \$790.17/mo.  <b>Go to step 12</b> to compare FEL review amount to current FEL.	
<b>12. Compare FEL review amount to current FEL</b>  $\% \text{ variance} = \frac{\text{current FEL} - \text{review FEL}}{\text{current FEL}} \times 100$	$\% \text{ var.} = \frac{\$1575.70 (6A) - \$1566.54 (10A)}{\$1575.70} \times 100$  $= \frac{\$9.16}{\$1575.70} \times 100$  $= .00581 \times 100$  $= .581\%$  The % difference between the current FEL and the R1 FEL is .581%—a less than 10% increase/decrease—so the worker continues to receive the current FEL amount of \$1575.70.	$\% \text{ var.} = \frac{\$830.21 (6B) - \$790.17 (11B)}{\$830.21} \times 100$  $= \frac{\$40.04}{\$830.21} \times 100$  $= .0482 \times 100$  $= 4.82\%$  The % difference between the current FEL and the R1 FEL is 4.82%—a less than 10% increase/decrease—so the worker continues to receive the current FEL amount of \$830.21.

Every January, between R1 and R2, 100% FEL benefits are indexed by CPI, and less-than-100% FEL benefits are indexed by Friedland. At R2 and any review due to a deterioration of the worker's condition which results in an increased NEL benefit the WCB repeats steps 7 through 12.

\* The VR plan may be amended before a file is referred for R1, which may change the worker's anticipated earnings. See 07-02-08.

R1 - 5 mai 1998	A - gains prévus après la lésion = 0 \$	B - gains prévus après la lésion = 225 \$/sem.
6. Indexation de l'indemnité pour PEF entre D1 et R1 • indemnité pour PEF de 100 % x IPC; • indemnité pour PEF de moins de 100 % x Friedland	PEF = 1 499,81 \$/mois 1 499,81 \$ x 1,02 (IPC 97) = 1 529,81 \$/mois 1 529,81 \$ x 1,03 (IPC 98) = 1 575,70 \$/mois PEF = 815,88 \$/mois 815,88 \$ x 1,005 (Fr. 97) = 819,96 \$/mois 819,96 \$ x 1,0125 (Fr. 98) = 830,21 \$/mois	PEF = 510 \$/sem. 510 \$ x 1,02 (IPC 96) = 510 \$/sem. 510 \$ x 1,02 (IPC 97) = 520,20 \$/sem. 510 \$ x 1,03 (IPC 98) = 535,81 \$/sem.
7. Indexation des gains bruts hebdomadaires d'avant la lésion selon l'IPC pour chaque 1 <sup>er</sup> janvier à compter du jour de la lésion	500 \$ x 1,02 (IPC 96) = 510 \$/sem. 510 \$ x 1,02 (IPC 97) = 520,20 \$/sem. 520,20 \$ x 1,03 (IPC 98) = 535,81 \$/sem.	500 \$ x 1,02 (IPC 96) = 510 \$/sem. 510 \$ x 1,02 (IPC 97) = 520,20 \$/sem. 520,20 \$ x 1,03 (IPC 98) = 535,81 \$/sem.
8. Conversion des gains bruts hebdomadaires indexés d'avant la lésion en GMN mensuels à l'aide de la Table des GMN et du CEN 01	GMN d'avant la lésion = 401,68 \$/sem. = 401,68 \$ x 4,3333 sem. = 1 740,60 \$/mois	GMN d'avant la lésion = 401,68 \$/sem. = 401,68 \$ x 4,3333 sem. = 1 740,60 \$/mois
9. Conversion des gains bruts hebdomadaires d'après la lésion en GMN mensuels à l'aide de la Table des GMN et CEN 01	GMN d'après la lésion = 0 \$	GMN d'après la lésion = 189,37 \$/sem. = 189,37 \$ x 4,3333 sem. = 820,60 \$/mois
10. Application de la formule PEF $PEF = \left( \begin{matrix} \text{GMN} \\ \text{d'avant} - \text{d'après la lésion} \end{matrix} \right) \times 90\%$	PEF = (1 740,60 \$ - 0 \$) x ,90 = 1 566,54 \$/mois	PEF = (1 740,60 \$ - 820,60 \$) x ,90 = 828,00 \$/mois
11. Application de la nouvelle règle d'indexation pour chaque 1 <sup>er</sup> janvier à compter du jour de la lésion pour les travailleurs ayant une capacité de gain après la lésion $PEF_{révisée} = PEF_{révisée} \times \frac{1 + [(75\% \times IPC) - 1\%]}{1 + IPC}$	PEF révisée = 828,00 \$ x $\frac{1 + 2\%}{1 + 1,5\%}$ = 828,00 \$ x ,9853 PEF révisée = 790,17 \$/mois	PEF révisée = 828,00 \$ x $\frac{1 + 2\%}{1 + 1,25\%}$ = 828,00 \$ x ,983 PEF révisée = 790,17 \$/mois
12. Comparaison de la PEF révisée avec la PEF actuelle $\text{diff.} = \frac{PEF_{révisée} - PEF_{actuelle}}{PEF_{actuelle}} \times 100$	diff. = $\frac{1\,575,70\$(6A) - 1\,566,54\$(10A)}{1\,575,70\$} \times 100$ = 9,16 % = $\frac{1\,575,70\$}{1\,575,70\$} \times 100$ = ,00581 x 100 = ,581 % La différence en % entre la PEF révisée à la R1 et la PEF actuelle est de ,581 % — une augmentation/diminution de moins de 10 %; le travailleur continue donc de recevoir une indemnité pour PEF de 1 575,70 \$.	diff. = $\frac{830,21\$(11B) - 790,17\$(6B)}{830,21\$} \times 100$ = 40,04 % = $\frac{830,21\$}{830,21\$} \times 100$ = ,0482 x 100 = 4,82 % La différence en % entre la PEF révisée à la R1 et la PEF actuelle est de 4,82 % — une augmentation/diminution de moins de 10 %; le travailleur continue donc de recevoir une indemnité pour PEF de 830,21 \$.
11. Application de la nouvelle règle d'indexation pour chaque 1 <sup>er</sup> janvier à compter du jour de la lésion pour les travailleurs ayant une capacité de gain après la lésion $PEF_{révisée} = PEF_{révisée} \times \frac{1 + [(75\% \times IPC) - 1\%]}{1 + IPC}$	PEF révisée = 828,00 \$ x $\frac{1 + 2\%}{1 + 1,5\%}$ = 828,00 \$ x ,9853 PEF révisée = 790,17 \$/mois	PEF révisée = 828,00 \$ x $\frac{1 + 2\%}{1 + 1,25\%}$ = 828,00 \$ x ,983 PEF révisée = 790,17 \$/mois
12. Comparaison de la PEF révisée avec la PEF actuelle $\text{diff.} = \frac{PEF_{révisée} - PEF_{actuelle}}{PEF_{actuelle}} \times 100$	diff. = $\frac{1\,575,70\$(6A) - 1\,566,54\$(10A)}{1\,575,70\$} \times 100$ = 9,16 % = $\frac{1\,575,70\$}{1\,575,70\$} \times 100$ = ,00581 x 100 = ,581 % La différence en % entre la PEF révisée à la R1 et la PEF actuelle est de ,581 % — une augmentation/diminution de moins de 10 %; le travailleur continue donc de recevoir une indemnité pour PEF de 1 575,70 \$.	diff. = $\frac{830,21\$(11B) - 790,17\$(6B)}{830,21\$} \times 100$ = 40,04 % = $\frac{830,21\$}{830,21\$} \times 100$ = ,0482 x 100 = 4,82 % La différence en % entre la PEF révisée à la R1 et la PEF actuelle est de 4,82 % — une augmentation/diminution de moins de 10 %; le travailleur continue donc de recevoir une indemnité pour PEF de 830,21 \$.
12. Comparaison de la PEF révisée avec la PEF actuelle $\text{diff.} = \frac{PEF_{révisée} - PEF_{actuelle}}{PEF_{actuelle}} \times 100$	diff. = $\frac{1\,575,70\$(6A) - 1\,566,54\$(10A)}{1\,575,70\$} \times 100$ = 9,16 % = $\frac{1\,575,70\$}{1\,575,70\$} \times 100$ = ,00581 x 100 = ,581 % La différence en % entre la PEF révisée à la R1 et la PEF actuelle est de ,581 % — une augmentation/diminution de moins de 10 %; le travailleur continue donc de recevoir une indemnité pour PEF de 1 575,70 \$.	diff. = $\frac{830,21\$(11B) - 790,17\$(6B)}{830,21\$} \times 100$ = 40,04 % = $\frac{830,21\$}{830,21\$} \times 100$ = ,0482 x 100 = 4,82 % La différence en % entre la PEF révisée à la R1 et la PEF actuelle est de 4,82 % — une augmentation/diminution de moins de 10 %; le travailleur continue donc de recevoir une indemnité pour PEF de 830,21 \$.
Chaque mois de janvier, entre R1 et R2, les indemnités pour PEF de 100 % sont indexées selon l'IPC et celles de moins de 100 %, selon le facteur d'indexation Friedland. Au moment de R2 et de toute révision par suite d'une détérioration de l'état du travailleur qui occasionne une augmentation de l'indemnité pour perte non économique (PNE) la CAT répète les étapes 7 à 12.		



## Calcul de la PEF

La plupart des étapes du calcul d'une indemnité pour PBF s'appliquent tant aux travailleurs **qui ont** une capacité de gain après la lésion qu'à ceux **qui n'en ont pas**. La seule différence est l'utilisation de l'IPC ou du facteur Friedland comme facteur d'indexation. Dans notre exemple, nous illustrons le cas d'un travailleur et, en utilisant les mêmes données, nous illustrons — à partir de l'étape 3 — les calculs selon que le travailleur a une capacité de gain après la lésion (A) ou qu'il n'en a pas (B).

Données					
Date de la lésion - 5 mai 1995	Gains bruts d'avant la lésion = 500 \$/sem.	CEN-01	D1 (calcul initial de la PEF) - 5 mai 1996	R1 (première révision de la PEF) - 5 mai 1998	
Facteurs d'indexation fictifs					
Friedland (Fr.)	(min. 0 %, max. 4 %)	IPC	(min. 0 %, pas de max.)	1 <sup>er</sup> janv. 1996	1 <sup>er</sup> janv. 1997
				2 % (.02)	3 % (.03)
				2 % (.02)	
				1 <sup>er</sup> janv. 1996	1 <sup>er</sup> janv. 1997
				1 <sup>er</sup> janv. 1998	

\* À partir d'ici, nous utiliserons l'équation abrégée:  $500 \$ \times 1,02 = 510 \$$

## FEL Calculation

Most steps for calculating a FEL benefit are common to workers who **do** and **do not** have the capacity to earn following the injury. They differ, however, in the effect of CPI indexing vs. Friedland indexing. In this example, we take one worker and using the same given information, illustrate—starting at step 3—the calculations if the worker has no post-injury earnings (A) and the calculations if the worker has the capacity to earn (B).

Given	Fictitious indexing factors	
Date of injury - May 5, '95 Pre-injury gross earnings = \$500 wk. NEC - 01 D1 (Initial FEL calculation) - May 5, '96 R1 (First FEL review) - May 5, '98	<b>CPI</b> (min. 0%, no max.)	<b>Friedland</b> (min. 0%, max. 4%)
D1 - May 5, '96	A - anticipated post-injury earnings = \$0	B - anticipated post-injury earnings = \$200 per week
1. Index weekly <i>pre-injury</i> gross earnings by CPI for each Jan. 1, since the injury	Indexed pre-injury gross earnings = \$500 + (\$500 x 2%) = \$500 + (\$500 x .02) = \$500 + \$10 = \$510/wk.*	Indexed pre-injury gross earnings = \$500 x 1.02 = \$510/wk.
2. Convert weekly indexed <i>pre-injury</i> gross earnings to monthly NAE using NAE Table & NEC 01	Pre-injury NAE = \$384.57/wk. = \$384.57 x 4.3333 wk. = \$1666.46/mo.	Pre-injury NAE = \$384.57/wk. = \$384.57 x 4.3333 wk. = \$1666.46/mo.
3. Convert weekly <i>post-injury</i> gross earnings to monthly NAE using NAE Table & NEC 01	Post-injury NAE = \$0	Post-injury NAE = \$172.25/wk. = \$172.25 x 4.3333 wk. = \$746.41/mo.
4. Apply FEL formula  $FEL = \left( \frac{\text{pre-injury NAE} - \text{post-injury NAE}}{\text{NAE}} \right) \times 90\%$	$FEL = (\$1666.46 - \$0) \times .90$ $= \$1499.81/\text{mo.}$  For the worker with <b>no</b> post-injury earnings the calculation is complete. <b>Go to step 6</b> for indexing on Jan. 1.	$FEL = (\$1666.46 - \$746.41) \times .90$ $= \$828.05/\text{mo.}$  For the worker <b>with</b> post-injury earnings, the calculation continues with <b>steps 5 and 6</b> .
5. Apply new indexing rule each January 1 since the injury for workers <i>with post-injury</i> earnings capacity   $\text{Adjusted FEL} = FEL \times \frac{1 + [(75\% \times \text{CPI}) - 1\%]}{1 + \text{CPI}}$		$\text{Adjusted FEL} = \$828.05 \times \frac{1 + [(75\% \times 2\%) - 1\%]}{1 + 2\%}$ $= \$828.05 \times \frac{1 + [(75 \times .02) - .01]}{1 + .02}$ $= \$828.05 \times \frac{1 + (.015 - .01)}{1.02}$ $= \$828.05 \times \frac{1 + .005}{1.02}$ $= \$828.05 \times \frac{1.005}{1.02}$ $= \$828.05 \times .9853$  Adjusted FEL = \$815.88/mo.  Go to step 6 for indexing on Jan. 1.

\* From here on we use the shortened calculation method: \$500 x 1.02 = \$510



USI 0	-	Unité des services intégrés
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USI 2	-	Toronto-Est
USI 3	-	Toronto-Nord
USI 4	-	Construction
USI 5	-	Centre-Ouest de l'Ontario
USI 6	-	Toronto-Ouest
USI 7	-	Centre-Sud de l'Ontario
USI 8	-	Toronto-Sud
USI Z	-	Unité des dossiers complexes (lésions)
USI 0	-	Unité des dossiers complexes (maladies)

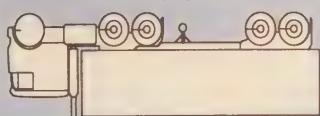
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1-800-387-0062	
1-800-387-0068	
1-800-387-0064	
1-800-465-5538	
1-800-465-9646	

Les nouveaux numéros de téléphone des unités de services intégrés sont les suivants :

(en Ontario)

Voici les numéros de téléphone généraux : (416) 344-1000; sans frais : 1-800-387-5540 (partout au Canada); 1-800-387-0750



**AVIS**  
La CAT a déménagé

au : 200, rue Front Ouest  
Toronto ON M5V 3J1

du : 2, rue Bloor Est  
Toronto ON M4W 3C3

1 %].

- indemnité pour PEF de 100 % x IPC;
- indemnité pour PEF de moins de 100 % x [(75 % de l'IPC) -

révisions :

indexe les indemnités pour PEF selon le même calcul qu'entre les  
Chaque 1<sup>er</sup> janvier suivant la révision finale de la PEF, la CAT

**révision finale**

**Indexation des indemnités pour PEF chaque année après la**

$$\text{différence en \%} = \frac{\text{PEF actuelle} - \text{PEF révisée}}{\text{PEF révisée}} \times 100$$

suivant :

Après avoir recalculé le montant de la PEF au moment de toute  
révision, la CAT compare le nouveau montant avec celui que le  
travailleur reçoit actuellement. Si la différence équivaut à une  
augmentation ou à une diminution de 10 % ou plus, le travailleur  
reçoit le nouveau montant. Si la différence est de moins de 10 %, le  
travailleur continue de recevoir le même montant. Le calcul  
servant à déterminer cette différence en pourcentage est le

**Comparaison du montant de la PEF révisée avec celui de la PEF**

également les nouvelles règles d'indexation (étape 5).

Lors des révisions, la CAT applique la formule PEF (étape 4) en  
utilisant les gains d'avant la lésion (indexés selon l'IPC) et les  
gains actuels du travailleur. Pour les travailleurs ayant des gains  
ou une capacité de gain après la lésion, la CAT applique

**Exemple (en encart)**

Étant donné que les calculs de la PEF utilisés dans notre  
exemple portent sur des révisions projetées dans le futur, nous  
avons utilisé un IPC fictif pour 1996, 1997 et 1998. Il en va de  
même pour le facteur d'indexation Friedland puisqu'il est basé sur  
l'IPC. De plus, comme la *Table des gains moyens nets* n'est pas  
disponible pour 1996 et 1998, nous utilisons celle de 1995 pour  
convertir les gains bruts en gains nets.

**Meilleurs vœux!**

**Bulletin des politiques**

Rédaction

**Bulletin des politiques**

Direction des politiques sur l'indemnisation

Commission des accidents du travail

200, rue Front Ouest, 18<sup>e</sup> étage

Toronto ON M5V 3J1

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# Indexation des indemnités pour PEF

Comme nous l'avons décrit dans le numéro de mai 1995 du *Bulletin des politiques*, la Loi 165 a introduit, le 1<sup>er</sup> janvier 1995, un nouveau facteur d'indexation — nommé facteur Friedland — et de nouvelles règles se rapportant à l'indexation des indemnités pour perte économique future (PEF) [articles 43 (4), 43 (5), 43 (6.1) de la Loi sur les accidents du travail (la Loi)].

En résumé, la CAT :

- continue d'indexer les gains moyens nets d'avant la lésion selon l'indice des prix à la consommation (IPC) avant de calculer ou de réviser toutes les indemnités pour PEF;
- applique les nouvelles règles d'indexation lorsqu'elle calcule les indemnités pour PEF de moins de 100 % au moment de la détermination initiale et des révisions des indemnités;
- continue d'indexer toutes les indemnités pour PEF de 100 % selon l'IPC chaque 1<sup>er</sup> janvier;
- indexe toutes les indemnités pour PEF de moins de 100 % selon la formule Friedland chaque 1<sup>er</sup> janvier.

Afin de démontrer comment la formule Friedland et les nouvelles règles d'indexation agissent sur les indemnités pour PEF, le présent numéro du *Bulletin des politiques* explique le calcul d'une indemnité pour PEF. Aux fins de comparaison, ce calcul présente deux situations possibles pour montrer la différence entre un travailleur qui a une capacité de gain après la lésion et celui qui n'en a pas.

Voici d'abord les étapes de base du calcul :

## 1. Indexation des gains bruts d'avant la lésion

La CAT rajuste les gains bruts d'avant la lésion du travailleur en appliquant l'IPC pour chaque 1<sup>er</sup> janvier à compter du jour de la lésion.

## 2. Conversion des gains bruts d'avant la lésion en gains moyens nets (GMN)

La CAT déduit des gains bruts du travailleur ses contributions probables au titre de l'impôt sur le revenu, du Régime de pensions du Canada et de l'assurance-chômage. Pour simplifier la tâche, la CAT crée chaque 1<sup>er</sup> janvier une table de conversion — *Table des gains moyens nets*. Pour utiliser la table, la CAT doit connaître le code d'exemption nette (CEN) actuel du travailleur.

**Conversion des gains bruts d'après la lésion en GMN**  
La CAT convertit en GMN les gains bruts actuels que le travailleur tire actuellement d'un emploi, ou ceux qu'il tirerait probablement d'un emploi approprié et disponible. (Voir politique 07-02-08.)

## 4. Application de la formule PEF

$$PEF = \left( \text{GMN d'avant la lésion} - \text{GMN d'après la lésion} \right) \times 90\%$$

Les travailleurs dont les gains après la lésion sont de zéro et qui n'auront pas de capacité de gain reçoivent une indemnité pour PEF de 100 %. Dans de tels cas, le calcul initial de la PEF se termine ici. Passer à l'étape 6 pour l'indexation du 1<sup>er</sup> janvier.

Les travailleurs qui ont des gains ou une capacité de gain après la lésion reçoivent une indemnité pour PEF de moins de 100 %. Passer aux étapes 5 et 6.

## 5. Application de la nouvelle règle d'indexation pour les travailleurs ayant des gains ou une capacité de gain après la lésion

La CAT rajuste le résultat obtenu par la formule PEF

(étape 4) :

- en le multipliant, pour chaque 1<sup>er</sup> janvier à compter du jour de la lésion, par la somme de un plus le facteur

d'indexation Friedland,  $1 + [(75\% \times \text{IPC}) - 1\%]$ , puis

- en le divisant, pour chaque 1<sup>er</sup> janvier à compter du jour de la lésion, par la somme de un plus l'IPC,  $1 + \text{IPC}$ .

L'équation mathématique équivalant à ce calcul (pour un an) est la suivante :

$$PEF \text{ rajustée} = PEF \times \frac{1 + \text{IPC}}{1 + [(75\% \times \text{IPC}) - 1\%]}$$

Remarque : Cette indexation s'applique également à chaque révision de la PEF, comme il est indiqué ci-dessous.

## 6. Indexation de l'indemnité pour PEF entre les révisions

Après la détermination initiale de la PEF (D1), la CAT indexe les indemnités pour PEF chaque 1<sup>er</sup> janvier de la façon suivante :

- indemnité pour PEF de  $100\% \times \text{IPC}$ ;
- indemnité pour PEF de moins de  $100\% \times [(75\% \text{ de l'IPC}) - 1\%]$ .

Nouveau calcul de la PEF au moment de la première (R1) et de la

deuxième révision (R2)

Les indemnités pour PEF sont recalculées :

- 24 mois (R1) après la D1;
- 60 mois (R2) après la D1;

- au moment de toute révision par suite d'une détérioration de l'état du travailleur qui occasionne une augmentation de l'indemnité pour perte non économique (PNE).



À la suite de l'enquête préliminaire

Lorsqu'une enquête permet de prouver qu'il y a eu méfait, le secteur administratif concerné, en consultation avec la DES, décide des mesures à prendre. S'il n'y a aucune preuve de méfait, aucune autre démarche n'est entreprise.

Cas transmis à la DES

Lorsqu'un prétendu méfait est confirmé, le secteur administratif transmet immédiatement à la DES le dossier accompagné d'une note de service détaillée.

Étude du cas et enquête de la DES

La DES étudie tous les cas de fraude soupçonnée qui lui sont présentés par les divers secteurs administratifs et, au besoin, mène une enquête. Lorsqu'elle termine son étude, la DES transmet au secteur administratif approprié un rapport faisant état de ses constatations et de ses recommandations sur les mesures à prendre.

Dans le cadre de son enquête, la DES a accès à tous les dossiers et documents pertinents, y compris l'accès aux enregistrements sonores et visuels, mais l'accès ne se limite pas aux vidéos-cassettes, aux bandes magnétiques et aux dossiers informatisés.

Intervention

Lorsqu'il y a des preuves convaincantes qu'une fraude a été commise, la CAT a le pouvoir de prendre des mesures administratives, comme régler l'affaire, imposer une pénalité ou créer un paiement excédentaire.

La Direction des services juridiques de la CAT peut entreprendre des poursuites civiles pour recouvrer l'argent ou les biens en cause. La DES peut aussi recommander que des poursuites criminelles soient intentées.

Poursuites

Si une infraction est commise aux termes de la Loi sur les accidents du travail, la Direction des services juridiques engage des poursuites formelles en vertu de la Loi sur les infractions provinciales.

Les corps policiers peuvent seuls décider d'intenter ou non des poursuites en vertu du Code criminel.

Confidentialité et accès à l'information

La CAT doit considérer comme confidentiels tous les renseignements qu'elle détient relativement à des activités frauduleuses. Les travailleurs, les employeurs et leurs représentants n'ont pas accès aux dossiers lorsque la CAT mène une enquête.

La CAT donne suite aux demandes d'accès aux dossiers seulement lorsque l'enquête du secteur administratif est terminée et qu'une décision a été rendue.

Contestation

Une personne qui fait l'objet d'une enquête peut contester une décision de la CAT. Toutefois, la CAT peut retarder la prise de décision jusqu'à ce que l'enquête soit terminée et que la DES ait fait ses recommandations.

Ces politiques et directives en matière de fraude s'appliquent à tous les cas de fraude soupçonnée qui ont été dépistés le 1<sup>er</sup> novembre 1995 ou après cette date. Pour obtenir de plus amples renseignements, veuillez vous référer à votre Manuel des politiques opérationnelles.

Remarque :

Le 1<sup>er</sup> novembre 1995, le gouvernement de l'Ontario a présenté un projet de loi modifiant la Loi sur les accidents du travail en ce qui a trait à la fraude au sein du régime d'indemnisation des travailleurs. Lorsque ce projet de loi aura été adopté, certaines politiques opérationnelles pourraient devoir être modifiées. Une prochain Bulletin des politiques fera état de ces modifications.

Taux d'intérêt postérieur au jugement

La CAT verse des intérêts sur les indemnités payées en retard selon le taux d'intérêt postérieur au jugement fixé trimestriellement en application de la Loi sur les tribunaux judiciaires. Ce taux correspond au taux d'escompte de la Banque du Canada (arrondi au nombre entier supérieur le plus près), plus 1 %. Le taux d'intérêt postérieur au jugement est publié chaque trimestre dans la Gazette de l'Ontario.

Trimestre

	1 <sup>er</sup>	2 <sup>e</sup>	3 <sup>e</sup>	4 <sup>e</sup>
1990	14 %	15 %	15 %	14 %
1991	14 %	11 %	11 %	10 %
1992	9 %	9 %	8 %	7 %
1993	10 %	8 %	7 %	6 %
1994	6 %	6 %	8 %	7 %
1995	8 %	10 %	9 %	8 %

## La CAT durcit sa position face à la fraude

- recouvrer les actifs de la CAT lorsqu'il y a eu fraude, tout en respectant les droits des personnes ou des entreprises soupçonnées de fraude, conformément à la Loi sur l'accès à l'information et la protection de la vie privée.

### Définition de la fraude

La CAT définit la fraude comme tout méfait ou acte malhonnête qui entraîne une perte réelle ou potentielle pour la CAT.

Il y a méfait ou acte malhonnête lorsque l'on :

- utilise de faux documents (acte de naissance, numéro d'assurance sociale, certificat de décharge de la CAT);
- facture la CAT, en toute connaissance de cause, pour des services qui n'ont pas réellement été dispensés à un travailleur blessé;
- travaille tout en réclamant des indemnités d'invalidité totale; déclare délibérément une masse salariale inférieure à la masse salariale réelle afin de payer des cotisations moins élevées.

Lorsqu'il soupçonne qu'il y a eu fraude, l'employé de la CAT

chargé du dossier doit immédiatement signaler la situation à un chef de service et, en consultation avec celui-ci, prendre des dispositions pour qu'une enquête préliminaire soit menée.

Cette enquête préliminaire est similaire aux enquêtes que la CAT mène dans le cadre de ses activités habituelles. Elle consiste principalement à recueillir les renseignements nécessaires à la prise des décisions administratives courantes, comme les décisions ayant trait à la preuve de l'accident, à la validité de la masse salariale ou aux genres d'activités commerciales exercées.

Dans ce numéro...

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Calcul de la PEF... (encart)

Numéros de téléphone des unités de services intégrés... page 4

La fraude est un problème qui touche l'industrie de l'assurance depuis des décennies et, malgré les mesures prises pour la contrer, rien n'indique qu'elle est moins fréquente.

Les commissions des accidents du travail du Canada — qui sont actives dans une large mesure comme faisant partie de l'industrie de l'assurance — font face à des problèmes de fraude uniques et travaillent sans relâche des mesures pour enrayer la fraude au sein des régimes d'indemnisation.

Confrontée à des activités frauduleuses au sein de son propre régime au cours des dernières années, la Commission des accidents du travail (CAT) de l'Ontario a réuni des représentants de ces secteurs administratifs clés afin d'élaborer une stratégie globale de lutte contre la fraude. Cette initiative a donné lieu à la mise sur pied de la Direction des enquêtes spéciales (DES) en 1993. Cette direction a pour objectif de « coordonner les mesures d'intervention de la CAT face aux allégations de fraude et de rendre les mesures qui s'imposent pour décourager au maximum tout usage frauduleux des services fournis par la CAT ».

Le 1<sup>er</sup> novembre 1995, la CAT a approuvé quatre politiques et directives opérationnelles en matière de fraude en vue d'appuyer le travail de la DES et des décideurs. Ces politiques ont été publiées dans le *Manuel des politiques opérationnelles* sous les titres suivants : *Fraude générale* (politique 01-03-01), *Fraude impliquant des fournisseurs de biens et de services* (politique 01-03-02), *Fraude impliquant des travailleurs* (politique 01-03-03) et *Fraude impliquant des employeurs* (politique 01-03-04).

Le présent numéro du *Bulletin des politiques* vous donne un aperçu de la politique portant sur la fraude générale. Cette politique décrit en gros les objectifs visés par la stratégie contre la fraude et établit une structure d'intervention pour la CAT lorsque celle-ci soupçonne qu'une fraude a été commise.

La politique intitulée *Fraude générale* précise que la CAT ne tolérera pas d'activités frauduleuses de la part des employeurs, des travailleurs ou des personnes à leur charge, ou encore des fournisseurs externes de biens et de services.

La CAT prend des mesures rigoureuses pour : protéger le régime d'indemnisation contre la fraude, en mettant en place des mécanismes de contrôle internes efficaces ainsi qu'en informant et en sensibilisant mieux ses employés; dépister rapidement les cas de fraude; enquêter avec équité, diligence et cohérence sur tous les cas de fraude soupçonnés; éliminer les pertes d'argent et d'actifs attribuables à la fraude;



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Public

# POLICY REPORT

APR 1 1996

University of Toronto

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Volume 9, Number 1 February 1996

## Bill 15 Highlights

**Bill 15—the Workers' Compensation and Occupational Health and Safety Amendment Act, 1995**—was proclaimed, on December 14, 1995.\*

Here, in brief, are some of the highlights of the bill.

### Purpose Clause (s.1)

The purpose of the *Workers' Compensation Act* (the *Act*) is to accomplish a number of objectives in a financially responsible and accountable manner.

Two new objectives are to prevent or reduce the occurrence of injuries and occupational diseases in the workplace, and promote health and safety in the workplace.

The objective requiring the board of directors to act in a financially responsible and accountable manner is enumerated as s.58(2). Section 58 deals with the directors' duty to act in good faith and in the best interests of the WCB.

### Governance structure (s.6)

Retroactive to November 1, 1995, the president—as appointed by the Lieutenant Governor in Council—exercises the powers and performs the duties of the board of directors, chair and president until a multi-stakeholder board of directors is in place.

### Policy direction (s.12)

The Minister of Labour's right to issue policy direction to the WCB is no longer limited to one year.

### Value for money audit (s.16)

The board of directors must ensure that at least one WCB program is reviewed annually—under direction of the Provincial Auditor—for cost, efficiency, and effectiveness.

### Memo of understanding (s.13)

The WCB and the Minister of Labour must enter into a memorandum of understanding every five years the terms of which are directed by the Minister.

The memo has three components

1. an annual strategic plan setting out the WCB's plans for the next 5 years
2. an annual statement setting out proposed priorities for administering the *Act* and regulations, and
3. an annual statement of investment policies and goals.

### Material change in circumstances (s.4 & s.19)

Workers and other benefit recipients must notify the WCB within 10 days of a material change in circumstances related to benefit entitlement, e.g., the worker finds a job.

Employers must notify the WCB within 10 days of a material change in circumstances related to employer

obligations under the *Act*, e.g., the employer expands operations into a new type of business activity.

### Overpayments (s.3 & s.24)

A benefit overpayment to a worker or an overpayment to an employer is a debt due and owing to the WCB at the time the overpayment is made.

### Collection of debts (s.14)

The WCB may deduct from money payable all or part of a debt due to the WCB. The WCB may also pursue other appropriate remedies.

### Employer registration (s.17)

Both Schedule 1 and Schedule 2 employers must register with the WCB within 10 days of becoming an employer.

### Offences & penalties (s.27)

Offences and penalties are now grouped in Part V of the *Act*.

The standard penalty for an offence under the *Act* is, upon conviction, a fine of up to

- \$25,000 or up to six months in jail, or both, for individuals, and
- \$100,000 for persons who are not individuals. ☐

\* The sections of *Bill 15* to do with the board of directors' appointments have yet to take effect. These provisions will come into force on a day to be named by proclamation of the Lieutenant Governor.

# Two new NEL policies

The Act provides that workers who suffer permanent impairment as a result of a work-related injury are entitled to compensation for non-economic loss (NEL); that workers attend a medical assessment with a NEL "roster" physician to determine the extent of their impairment; and that the WCB uses the NEL roster physician's findings as the basis for the worker's permanent impairment rating and NEL benefit calculation.

Two recently introduced NEL policies address the manner in which WCB decision-makers approach exceptional circumstances (OPM 05-06-14), and redeterminations (OPM 05-06-15).

**Q.** *What happens if a worker who has a permanent impairment is unable to attend a NEL medical assessment?*

If a worker has moved out of the province before either the initial NEL assessment or a re-assessment, the WCB bases the NEL rating on the medical information in the claim file. If that information is insufficient, the WCB requests more from the worker's treating physician. If the treating physician is unable to provide more, the WCB asks the worker to return to Ontario for examination by a NEL roster physician.

If a worker dies, or is too ill to attend either the initial NEL assessment or a re-assessment, the WCB uses the medical information on file to determine or redetermine the NEL benefit. If that information is insufficient, the WCB requests more from the worker's treating physician.

**Q.** *What happens if a worker's permanent impairment worsens after the WCB determines the NEL benefit?*

The worker can apply to the WCB for a redetermination of the NEL benefit if

- 12 months have passed since the worker's last NEL decision, and
- the worker's condition has significantly deteriorated, and
- the deterioration was not anticipated, i.e., it did not appear on the previous assessment report or, if it did, it was not predicted with enough certainty to contribute to the NEL benefit.

**Q.** *What if the NEL benefit compensates for multiple permanent impairments, but only one has worsened?*

A NEL benefit may compensate for more than one permanent impairment resulting from the same injury/disease, so workers must clearly identify the impairment that has deteriorated. Only that impairment is reassessed.

A redetermination of one or all of the component impairments resets the 12-month clock for the next redetermination.

**Q.** *What steps are taken to have a NEL benefit redetermined?*

When workers advise their adjudicators that their permanent impairment has worsened, they can be provided with a copy of their last NEL medical report to take to their own treating physician. The treating physician reports new findings or measurable changes in the worker's condition.

With this new information, the adjudicator determines

- if the worker's condition has changed to such a significant extent that a re-assessment by a NEL roster physician is required
- the permanent worsening date (PWD). This is the date from which the new permanent impairment rating takes effect.

From here on, the process is the same as an initial NEL determination (OPM 05-06-03).

**Q.** *Does the WCB make exceptions to the redetermination criteria?*

The WCB reviews NEL benefits without applying the 12-month criterion if the worker's permanent impairment deteriorates rapidly and this deterioration was not anticipated at the time of the last NEL medical assessment. The WCB uses the medical information on file if a worker dies, or is too ill to attend a NEL medical reassessment, because of the deterioration of the permanent impairment.

**Q.** *How is a redetermined NEL benefit paid?*

The payment a worker receives depends on how the prior NEL was paid, and the amount of the new NEL payment.

Previous NEL payment	New NEL payment	
	\$10,000 or less	Over \$10,000
Monthly	Monthly	Monthly
Lump sum	Lump sum	Worker's choice



## Transcripts/reports authenticated

The WCB recently reviewed its policy on *Admissible Evidence* with respect to transcripts and written reports of audio and visual recordings.

As a result of the WCB's review the policy on admissible evidence was split into two policies, *Admissible Evidence* and *Audio/Visual Recordings*. The latter policy now requires that **transcripts** and written reports (from here on referred to as transcripts) of audio and visual recordings be authenticated. This approach complements existing guidelines which require that the actual audio and visual **recordings** be authenticated when submitted to the WCB.

To authenticate a transcript the author must sign a statement

- confirming that the transcript is a true reproduction of the recording, or a true narrative describing the contents of the recording, and
- indicating where and when (date and time) the transcript was prepared.

If transcripts received on or after December 1, 1995 are not authenticated, they are returned to their authors for authentication and resubmission.

For further information see *Admissible Evidence*, OPM 09-01-06, and *Audio/Visual Recordings*, OPM 09-01-09. □

## Chaperones now required for WCB medical examinations

A recent change in policy requires that chaperones be present any time a worker must undress for a medical examination by a WCB medical consultant.

In the past, the presence of a chaperone during an examination was optional, at the discretion of the worker. Now, medical consultants inform workers of the WCB's policy on chaperones, and if a worker does not agree to have a chaperone present, the medical consultant decides whether to proceed with the examination.

In some cases a relative, friend, or representative of the worker may be present during an examination, however, the WCB does not consider these individuals to be chaperones.

WCB policy directs that chaperones must be employees of the WCB, and the name of the WCB-appointed chaperone must be included in the medical consultant's report. □

# POLICY REPORT



Workers'  
Compensation  
Board

Commission  
des accidents  
du travail

*Policy Report* is free. It is published under the authority and direction of the Benefits Policy Branch of the Workers' Compensation Board. If there is any conflict between information in this publication and the *Workers' Compensation Act* or WCB approved policy documents, the *Act* or the approved policy governs.

In this publication, the "*Act*" refers to the *Workers' Compensation Act* unless otherwise stated, and "OPM" refers to the WCB *Operational Policy* manual.

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# 1996 facts and figures

Each year, WCB benefits are indexed to help keep pace with inflation. On the left, you'll find the applicable section of the *Act* and the originally legislated dollar amount. On the right, you'll find the latest indexed figures.

Section of the Act	Description	1995 \$ - Amount	1996 \$ - Amount
35(1)(a)	Lump sum to surviving spouse: Base amount = \$40,000 Age factor: Plus/minus \$1,000 for each year spouse is under/over age 40 Maximum lump sum = \$60,000 Minimum lump sum = \$20,000	54,949.79 1,373.74 82,424.66 27,474.88	55,389.38 1,384.73 83,084.05 27,694.68
35(7)	Aggregate lump sum payment for children when there is no surviving spouse = \$40,000	54,949.79	55,389.38
35(9)	Minimum burial or cremation expenses = \$1500	2,060.61	2,077.09
35(17)	When more than one person is entitled to receive periodic and lump sum payments as a spouse, the total periodic payment may not exceed • 90% of worker's net average earnings (NAE) at the time of injury, and • the total lump sum payment may not exceed \$60,000	82,424.66	83,084.05
38	Maximum earnings ceiling: 175% of the avg. industrial wage for Ontario for the year in which the accident takes place For more information about maximum earnings ceiling, see OPM 05-01-02.	55,400.00	55,600.00
39(1)	The minimum temporary total disability benefit to a worker is • \$10,500 per year when the NAE are equal to or more than \$10,500 or • the actual NAE if earnings are less than \$10,500 per year	15,145.55	15,266.71
39(3)	The minimum compensation amount used for spouse and children under s.35(4),(5),(6) = \$11,025	15,145.55	15,266.71
42	NEL (non-economic loss) benefit: Base amount = \$45,000 Age factor: Plus/minus \$1,000 for each year worker is under/over age 45, to a maximum of \$20,000  The benefit is paid as a lump sum if it is \$10,000 or less	50,973.44 1,133.13 22,654.41 11,327.20	51,381.23 1,142.20 22,836.01 11,417.82
44(7)	Retirement Pension: Pension is paid as a lump sum if it yields less than \$1,000 per year	1,132.74	1,141.80
50(3)	Maximum clothing allowance: • upper limb prosthesis • lower limb prosthesis/back brace/leg brace	252.77 505.55	254.79 509.59

Note: For 1996, the indexing amount using the Consumer Price Index (CPI) is 2.4% and the Friedland formula amount is 0.8%. For an explanation about how these indexing factors work, see *Policy Report* Volume 8 Number 1.





Workers'  
Compensation  
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*February, 1996*

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# Faits et chiffres pour 1996

Chaque année, la CAT indexe ses indemnités en fonction des variations du taux d'inflation. Dans les deux premières colonnes, vous trouverez respectivement le numéro de l'article de la Loi ainsi qu'une description des indemnités et les montants prévus par la Loi. Les deux colonnes de droite indiquent les montants indexés pour 1995 et 1996.

Articles de la Loi	Description et montants prévus par la Loi	Montants pour 1995	Montants pour 1996
35 (1) a)	Paiement forfaitaire au conjoint survivant : Montant de base = 40 000,00 \$ Majoration/diminution de 1 000,00 \$ pour conjoint de moins/de plus de 40 ans, pour chaque année entre son âge et l'âge de 40 ans. Maximum = 60 000,00 \$ Minimum = 20 000,00 \$	54 949,79 \$ 1 373,74 \$ 82 424,66 \$ 27 474,88 \$	55 389,38 \$ 1 384,73 \$ 83 084,05 \$ 27 694,68 \$
35 (7)	Paiement forfaitaire total de 40 000,00 \$ à l'enfant ou aux enfants (aucun conjoint survivant).	54 949,79 \$	55 389,38 \$
35 (9)	Frais d'inhumation ou d'incinération : minimum = 1 500,00 \$.	2 060,61 \$	2 077,09 \$
35 (17)	Indemnités versées à plus d'une personne, à titre de conjoint : • Total des versements périodiques : jusqu'à un maximum de 90 % des gains moyens nets du travailleur, au moment de la lésion. • Montant forfaitaire : maximum = 60 000,00 \$.	82 424,66 \$	83 084,05 \$
38	Montant maximal des gains moyens : 175 % du salaire moyen prévalant dans l'industrie en Ontario durant l'année où l'accident est survenu. Pour obtenir plus de renseignements sur le montant maximal des gains moyens, consulter la politique 05-01-02 du <i>Manuel des politiques opérationnelles</i> .	55 400,00 \$	55 600,00 \$
39(1)	L'indemnité minimale payable en cas d'invalidité totale temporaire correspond : • à 10 500,00 \$ par année si les gains moyens nets au moment de l'accident sont de 10 500,00 \$ ou plus; • au montant des gains moyens nets au moment de l'accident si ceux-ci sont inférieurs à 10 500,00 \$ par année.	15 145,55 \$	15 266,71 \$
39 (3)	L'indemnité minimale à laquelle ont droit les enfants à charge, en vertu des par. 35 (4), (5), (6), est de 11 025,00 \$ par année.	15 145,55 \$	15 266,71 \$
42	Indemnité pour perte non économique (PNE) : Montant de base = 45 000,00 \$ Facteur d'âge : plus/moins 1 000,00 \$ pour chaque année que le travailleur a moins/plus de 45 ans; maximum = 20 000,00 \$	50 973,44 \$ 1 133,13 \$ 22 654,41 \$ 11 327,20 \$	51 381,23 \$ 1 142,20 \$ 22 836,01 \$ 11 417,82 \$
44 (7)	Versements de pension de retraite : Seuil de 1 000,00 \$ déterminant si la pension est versée sous forme de paiement forfaitaire. L'indemnité est versée sous forme de paiement forfaitaire si elle est inférieure ou égale au seuil. Seuil de 10 000,00 \$ servant à déterminer le mode de paiement.	1 132,74 \$	1 141,80 \$
50 (3)	Allocation vestimentaire : Montant maximal : • prothèse à un membre supérieur • prothèse à un membre inférieur, corset ou attelle à la jambe	252,77 \$ 505,55 \$	254,79 \$ 509,59 \$

Remarque : Pour 1996, les montants indexés selon l'IPC sont multipliés par 2,4 % et ceux indexés selon le facteur Friedland par 0,8 %. Pour obtenir des renseignements sur l'application des facteurs d'indexation, se reporter au *Bulletin des politiques*, Vol. 8, n° 1.

# Authentification des trans- criptions et des rapports

La CAT a récemment réétudié sa politique sur la *Preuve admissible* en ce qui a trait aux transcriptions et aux rapports écrits présentant le contenu

d'enregistrements sonores ou visuels.

Par suite de l'étude menée par la CAT, la politique portant sur la preuve admissible a été scindée en deux politiques : *Preuve admissible* et *Enregistrements sonores ou visuels*. Cette dernière politique requiert maintenant que les **transcriptions** d'enregistrements sonores ou visuels doivent être authentifiées. Cette approche est complémentaire aux directives existantes requérant que les **enregistrements** sonores ou visuels présentés à la CAT soient authentifiés.

Pour authentifier une transcription, l'auteur doit signer une déclaration :

- confirmant que la transcription est une reproduction exacte de l'enregistrement, ou un texte fidèle décrivant le contenu de l'enregistrement;
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Pour plus de renseignements, veuillez consulter les politiques 09-01-06 (*Preuve admissible*) et 09-01-09 (*Enregistrements sonores ou visuels*).

## La présence d'un chaperon est maintenant requise lors de tous les examens médicaux de la CAT

Un changement récent apporté à la politique exige maintenant qu'un chaperon soit présent lorsque les travailleurs doivent se dévêtir pour subir un examen effectué par un médecin consultant de la CAT.

Par le passé, la présence d'un chaperon lors d'un examen était optionnelle et laissée à la discrétion du travailleur. Maintenant, les médecins consultants informent les travailleurs de la nouvelle politique de la CAT en matière de chaperons, et si un travailleur n'accepte pas qu'un chaperon soit présent, le médecin consultant peut décider de procéder ou non à l'examen.

Dans certains cas, un parent, un ami ou un représentant du travailleur peut être présent lors de l'examen. Toutefois, la CAT ne considère pas ces personnes comme des chaperons.

La politique de la CAT exige que les chaperons soient des employés de la CAT et que le nom du chaperon désigné par la CAT soit indiqué dans le rapport du médecin consultant.



Le *Bulletin des politiques* est gratuit. Il est publié par la Direction des politiques sur l'indemnisation de la Commission des accidents du travail. S'il y a contradiction entre les renseignements contenus dans la présente publication et la *Loi sur les accidents du travail* ou les politiques approuvées de la Commission, c'est à la *Loi* ou aux politiques approuvées qu'il faut se référer.

Dans la présente publication, «la Loi» fait référence à la *Loi sur les accidents du travail*, à moins d'indication contraire, Commission et CAT, à la Commission des accidents du travail, et «MPO», au *Manuel des politiques opérationnelles*.

La Direction publie également le *Manuel de la classification des employeurs\** ainsi qu'un lexique bilingue. Si vous désirez acheter un de ces manuels ou le lexique, ou obtenir le *Bulletin des politiques*, appelez le service de Publication des politiques au (416) 344-4355.

\* Ce manuel n'est pas encore disponible en français.

Veuillez adresser vos questions ou commentaires à :

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*Bulletin des politiques*

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Commission des accidents du travail

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Toronto ON M5V 3J1

Téléphone : (416) 344-4330

Télécopieur : (416) 344-4333



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# Deux nouvelles politiques sur la PNE

La Loi prévoit que le travailleur qui souffre d'une déficience permanente résultant d'une lésion reliée au travail a droit à une indemnité pour perte non économique (PNE). Le travailleur est soumis à une évaluation médicale effectuée par un médecin du tableau de la PNE afin que ce médecin évalue l'importance de la déficience du travailleur. La Commission se base sur les constatations du médecin du tableau pour établir le degré de déficience permanente du travailleur et le montant de l'indemnité pour PNE.

pour PNE entraîne un nouveau compte de 12 mois avant la nouvelle détermination suivante.

**Q.** Comment procède-t-on à la nouvelle détermination d'une indemnité pour PNE?

Lorsqu'un travailleur avise son agent que sa déficience permanente s'est aggravée, il peut obtenir une copie de son dernier rapport médical relatif à la PNE qu'il doit présenter à son médecin traitant. À partir de ce rapport, le médecin traitant émet de nouvelles constatations ou rend compte de modifications mesurables portant sur la déficience du travailleur.

À l'aide de ces nouveaux renseignements, l'agent détermine si la déficience du travailleur a changé suffisamment pour justifier une réévaluation de la part d'un médecin du tableau de la PNE;

• quelle est la «date d'aggravation permanente» (DAP), Il s'agit de la date de prise d'effet du nouveau taux de déficience permanente.

Ensuite, la procédure est la même que celle suivie lors de la détermination initiale de l'indemnité pour PNE (pol. 05-06-03).

**Q.** La CAT fait-elle des exceptions relativement aux critères de nouvelle détermination?

La CAT révisé l'indemnité pour PNE sans appliquer le critère portant sur le compte de 12 mois si la déficience permanente du travailleur s'est aggravée rapidement et si celle-ci n'était pas prévue au moment de la dernière évaluation médicale pour PNE.

La CAT utilise les renseignements médicaux contenus dans le dossier si, par suite de la détérioration de sa déficience permanente, le travailleur décède ou est trop malade pour se présenter à l'évaluation médicale pour PNE.

**Q.** Quel est le mode de versement de l'indemnité pour PNE résultant d'une nouvelle détermination?

Le mode de versement d'une indemnité pour PNE résultant d'une nouvelle détermination est établi en fonction du mode de versement de l'indemnité pour PNE initiale et du montant de la nouvelle indemnité.

Montant global	Mensuel	Nouveau paiement pour PNE	
		PNE antérieur	10 000 \$ ou moins
Montant global	Mensuel	Plus de 10 000 \$	Choix du travailleur

Les deux nouvelles politiques portant sur la PNE traitent de la procédure que suivront les décideurs de la CAT lorsqu'ils auront à tenir compte de circonstances exceptionnelles (pol. 05-06-14) et à traiter les nouvelles déterminations d'indemnité pour PNE (pol. 05-06-15).

**Q.** Qu'arrive-t-il si un travailleur ayant une déficience permanente est incapable de se présenter à une évaluation médicale pour PNE?

Si un travailleur a déménagé à l'extérieur de la province avant l'évaluation pour PNE initiale ou une réévaluation pour PNE, la CAT établit le taux de la PNE en fonction des renseignements médicaux contenus dans le dossier. Si ces renseignements sont insuffisants, la CAT demande des renseignements supplémentaires au médecin traitant du travailleur. Si le médecin traitant n'est pas en mesure de fournir plus de renseignements, la CAT demande au travailleur de revenir en Ontario pour subir un examen par un médecin du tableau de la PNE.

Si le travailleur décède ou est trop malade pour se rendre à l'évaluation pour PNE initiale ou à la réévaluation pour PNE, la CAT utilise les renseignements médicaux contenus dans le dossier pour déterminer ou réviser l'indemnité. Si ces renseignements sont insuffisants, la CAT demande des renseignements supplémentaires au médecin traitant du travailleur.

**Q.** Qu'arrive-t-il lorsque la déficience permanente d'un travailleur s'aggrave après que la CAT a déterminé son indemnité pour PNE?

Le travailleur peut demander une «nouvelle détermination» de l'indemnité pour PNE s'il respecte les critères suivants :

- Douze mois se sont écoulés depuis la dernière décision portant sur son indemnité pour PNE.
- L'état du travailleur s'est détérioré de façon importante.
- La détérioration n'était pas prévue, c.-à-d. qu'elle n'était pas mentionnée dans le rapport d'évaluation précédant ou, si elle l'était, elle n'était pas prévue avec suffisamment de certitude pour qu'on en tienne compte dans le calcul de l'indemnité pour PNE.

**Q.** Qu'arrive-t-il si l'indemnité pour PNE indemnise le travailleur pour plus d'une déficience, mais qu'une seule d'entre elles s'est aggravée?

Il peut arriver qu'une indemnité pour PNE indemnise un travailleur pour plus d'une déficience permanente découlant d'une même lésion ou maladie. Dans un tel cas, le travailleur doit indiquer clairement la déficience qui s'est aggravée. Seule cette déficience fera l'objet d'une réévaluation. La nouvelle détermination de l'indemnité pour PNE relative à une ou à toutes les déficiences faisant l'objet d'une indemnité

# BULLETIN des POLITIQUES

Une publication de la Commission des accidents du travail de l'Ontario

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Volume 9, numéro 1 Février 1996

## Points saillants de la Loi 15

### Directives en matière de politique (art. 12)

Le droit du ministre du Travail d'émettre à la Commission des directives en matière de politiques n'est plus limité à une période d'un an.

### Vérification de l'optimisation (art. 16)

Le conseil d'administration doit faire en sorte que chaque année au moins un des programmes offerts par la Commission soit examiné (sous la direction du vérificateur provincial) au plan des coûts, de l'efficacité et de l'efficacité.

### Protocole d'entente (art. 13)

Tous les cinq ans, la Commission et le ministre du Travail concluent un protocole d'entente ne contenant que les conditions qu'ordonne le ministre. Le protocole d'entente comprend trois composantes :

1. un plan stratégique annuel énonçant les projets de la Commission pour les cinq années suivantes;
2. un énoncé annuel des priorités qu'elle entend établir aux fins de l'application de la Loi et des règlements;
3. un énoncé annuel des politiques et objectifs de la Commission en matière de placement.

### Changement important (art. 4 et 19)

Quiconque reçoit des prestations doit aviser la Commission de tout changement important dans les circonstances en ce qui concerne son droit à des prestations (p. ex. le travailleur se trouve un emploi), et ce dans les 10 jours qui suivent le changement.

L'employeur doit aviser la Commission de tout changement important dans les circonstances en ce qui concerne les obligations que lui impose la Loi

La Loi 15 — Loi modifiant la Loi sur les accidents du travail et la Loi sur la santé et la sécurité au travail — a été promulguée le 14 décembre 1995\*. Les paragraphes qui suivent décrivent brièvement certains des points saillants de cette loi.

### Objet de la loi (art. 1)

L'objet de la Loi sur les accidents du travail (la Loi) est d'atteindre un certain nombre d'objectifs en pratiquant une saine gestion financière assortie de l'obligation de rendre compte.

Les deux nouveaux objectifs consistent à :

- empêcher ou réduire la survenance de lésions et de maladies professionnelles au travail; et,
- promouvoir la santé et la sécurité dans les milieux de travail.

L'objectif selon lequel le conseil d'administration doit pratiquer une saine gestion financière assortie de l'obligation de rendre compte constitue maintenant le paragraphe 58 (2). L'article 58 traite de l'obligation des membres du conseil d'administration d'agir de bonne foi au mieux des intérêts de la Commission.

### Structure de la régie (art. 6)

Rétroactivement au 1<sup>er</sup> novembre 1995, le président de la Commission, nommé par le lieutenant-gouverneur en conseil, exerce les pouvoirs et les fonctions du conseil d'administration, du président du conseil et du président de la Commission jusqu'à ce qu'un conseil nommé.

(p. ex. l'employeur croit et exerce un nouveau genre d'activité commerciale), dans les 10 jours qui suivent le changement.

### Montants excédentaires (art. 3 et 24)

Le montant excédentaire versé à un travailleur ou à un employeur devient une créance de la Commission au moment où le montant excédentaire est versé.

### Recouvrement des créances (art. 14)

La Commission peut déduire des sommes qu'elle doit payer la totalité ou une partie des sommes qui lui sont dues. La Commission peut également exercer d'autres recours qu'elle estime appropriés.

### Inscription de l'employeur (art. 17)

L'employeur qui fait partie d'une industrie figurant à l'annexe 1 ou 2 doit s'inscrire auprès de la Commission au plus tard 10 jours après qu'il est devenu un employeur.

### Infractions et peines (art. 27)

Les infractions et les peines sont maintenant regroupées dans la partie V de la Loi.

La peine habituelle pour quiconque est déclaré coupable d'une infraction prévue par la Loi est :

- une amende d'au plus 25 000 \$ et un emprisonnement d'au plus six mois, ou une seule de ces peines, s'il s'agit d'une personne physique;
- une amende d'au plus 100 000 \$ s'il ne s'agit pas d'une personne physique.

\* Les parties de la Loi 15 ayant trait à la nomination des membres du conseil d'administration ne sont pas encore entrées en vigueur. Ces dispositions prendront effet à une date déterminée par le lieutenant-gouverneur.



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# POLICY REPORT

A publication of the Workers' Compensation Board of Ontario

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- Parental leave
- Clarification

Volume 9, Number 3

June 1996

## The Appeals Process

*The WCB aims to resolve disputes as early in the adjudicative process as possible.*

Between 1990 and 1994, the number of objections the WCB received almost tripled: from 7,457 to 45,231. These objections covered a wide range of issues from benefits entitlement, to re-employment, to employer assessment. They clogged the appeals system down, and clients experienced lengthy delays. In 1995, the WCB phased in a new system to deal with objections more effectively. So far, the results have been encouraging.

The new system is based on the premise that if the WCB better communicates the facts, policy, and law behind each decision at the outset, there will be fewer objections overall, more will be resolved in the operating areas, and those received in the Appeals Branch will be more focused than in the past.

### A new role for front-line staff

The appeals system's reform began where most appeals begin: with front-line decisions made in the operating areas. In the past, when decision-makers such as adjudicators or caseworkers made an adverse decision, they would write a letter advising the affected party of the right

to object. Now, decision letters invite the party to call and discuss their concerns first, before objecting. This gives the decision-maker and the party a chance to review the rationale for the decision, and clear up any misunderstandings.

The WCB normally invites the worker and the employer to work with the WCB to settle a dispute.

### Access - getting a copy of the claim file

As soon as an issue in dispute is identified, the WCB sends the objecting party a copy of the claim file. (Employers do not initially receive the medical information in the claim file.)

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In entitlement cases, the WCB waits to receive the completed objection form before sending the other party a copy of the file. The objection form also prompts the WCB to send file updates to the parties who were previously sent the file.

If after calling the decision-maker, the party continues to dispute the original decision, the WCB sends him or her a copy of the claim file, and an objection form. See Access...(inset).

Again, the hope is that the party will better understand the WCB's decision after reading the claim file. And while reading the file, the party may spot other issues that the decision-maker should review before the objection proceeds.

To file an objection, the party completes the form, explaining the reasons for the dispute, and sends it in to the WCB. If the party has any new information to add, he or she should send it along with the form. The better the information available to decision-makers is, the more informed their decisions will be.

### Two streams

At this point in the process, the WCB streams disputes according to the type of issue they involve. Disputes follow the **mediation stream** if they involve vocational rehabilitation (VR) or return-to-work

issues. They follow the **entitlement stream** if they involve claims entitlement or revenue issues.

## The mediation stream

The *Act* allows the WCB only 60 days from the time a mediation stream objection is registered, to make a final decision.

### Step 1 - Screening

Each new case is immediately assigned to a mediator, who reviews it to ensure that

- the disputed issue concerns VR or return to work, and
- the file is ready—all relevant entitlement issues are resolved, there is a work-related impairment (in all but re-employment disputes), and
- the worker believes he or she can do some kind of work.

The mediator then calls the parties to tell them about the dispute and explain the mediation process, emphasizing that it is confidential and voluntary. Any of the parties—the worker, employer, or WCB decision-maker—may turn down the WCB's offer to mediate, in which case the dispute goes directly to a hearing before a reinstatement officer.

### Step 2 - Mediating

The mediator's next step is to define the issue in dispute. To do this, the mediator talks to the parties: trying to fill in gaps in their knowledge that might be contributing to the dispute; and giving them insight into each other's position, and WCB policy.

The mediator encourages free discussion, looking for ways to resolve the dispute, and suggesting possible solutions to the parties. Ideally, the process concludes with an agreement. Otherwise, the mediator stops the discussion approximately 21 days after it started. Where necessary, the WCB may decide to continue the mediation beyond 21 days.

### Step 3 - Decision-making

When mediation fails to resolve the issue, the parties may either

- ask the mediator to make the final decision of the WCB, (to do so,

the parties must waive their right to keep the information they have shared with the mediator confidential, so that the mediator's decision can be added to the claim file), or

- ask that the decision be rendered by a reinstatement officer, after an oral hearing.

### Outcomes

If an objecting party withdraws from mediation but later chooses to dispute the issue again, the WCB will not provide further mediation and will treat the operating area's decision as the final decision of the WCB. Other outcomes—like a mediated settlement, a mediator's decision, or a reinstatement officer's decision—all represent final decisions of the WCB.

## The entitlement stream

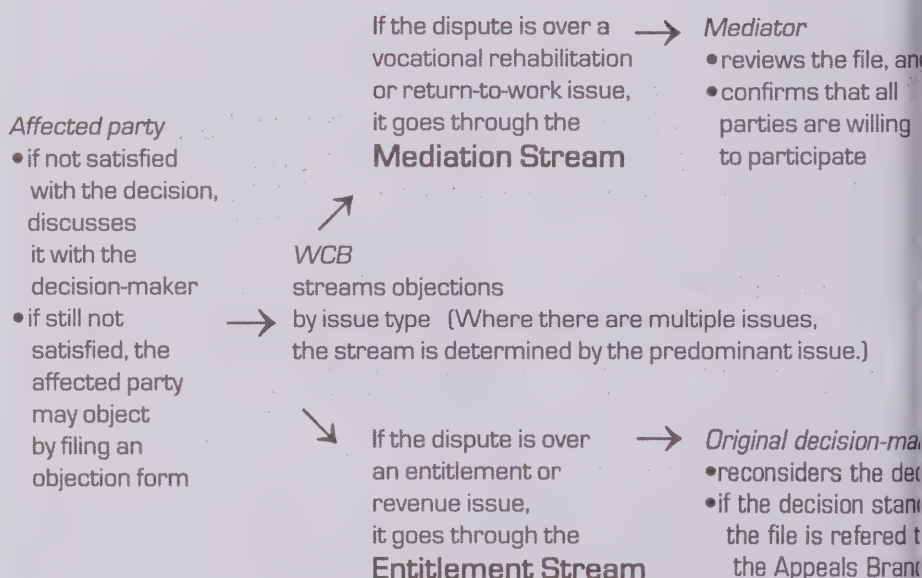
In entitlement cases, the WCB directs the objection form and any new information received, to the decision-maker, before sending it on to the Appeals Branch.

The decision-maker **reconsiders** the original decision and addresses new issues, if any have come up. If the decision-maker does not change the decision, a manager does a final check to ensure all enquires have been made and there are no outstanding issues, before referring the objection to the access area (see box p.1) and the Appeals Branch.

Appeals Branch staff then log the objection and, once it reaches the top of the case inventory, assign it to an appeals officer. Each appeals officer is responsible for cases from a particular part of the province. This encourages good working relationships with the employer and worker communities in their area, and allows them to learn about local industries.

Appeals officers perform a single comprehensive review of a file, which replaces the two tiers of the old appeals process: the paper review and the oral hearing.

## The WCB streams objections





This one review can take whatever form best suits the case at hand. After looking into the case and discussing it with the parties, appeals officers may ask for written submissions, or they may find that further enquiries are necessary. (Any new information they gather is added to the claim file and shared with the parties.)

As often as possible, appeals officers try to resolve disputes by making decisions in light of the information on file and any new information or submissions they receive. They reserve oral hearings for cases hinging on complex factual issues or personal credibility. However, appeals officers will hold an oral hearing at the request of either party.

#### Outcome

Appeals officers address the issue in dispute, and any additional issues that need to be addressed to achieve a full and sensible outcome. For example: an appeals officer who grants initial

entitlement may also decide on the nature, level, and duration of benefits payable up to the time of the decision.

Like mediation outcomes, appeals officers' decisions represent the WCB's final decision on the issue under review, and can only be appealed to the Workers' Compensation Appeals Tribunal (WCAT) — an external body which provides the final review of WCB decisions.

#### Objections involving claims entitlement and VR

Some objections involve both claims entitlement and VR issues. These cases generally go through the entitlement stream, rather than the mediation stream. However, these cases will go through mediation if

- the worker might return to work with the accident employer, or
- the VR issue involved does not depend on the entitlement issue.

#### Objections to non-economic loss (NEL) decisions

In most cases, NEL objections are not reviewed by appeals officers but by NEL appeal decision-makers. Like appeals officers, their decisions are the final decisions of the WCB, which can only be appealed to WCAT. Appeals officers only handle NEL appeals if the NEL is among other issues under review, or if the NEL was rated 0%.

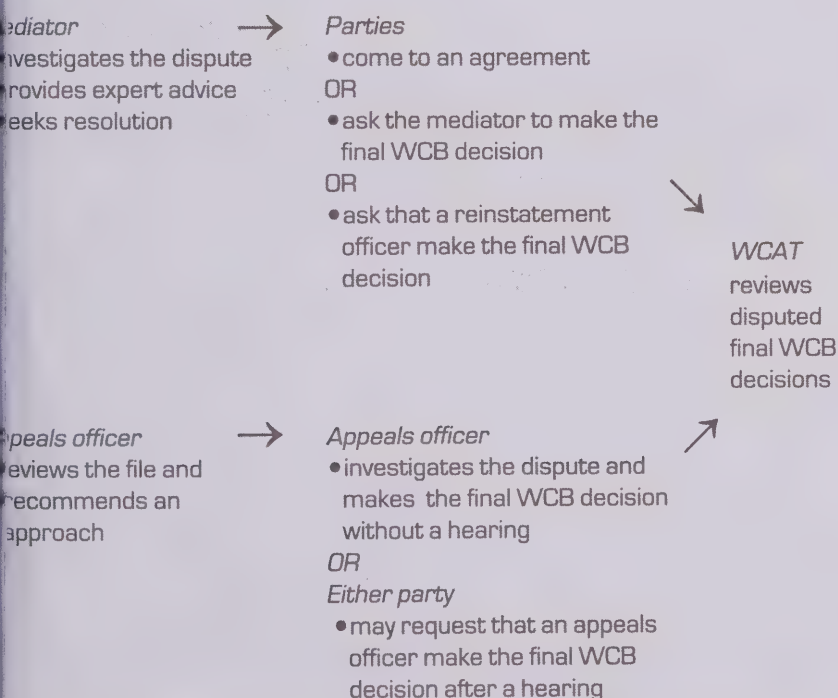
#### Consider this before you object

Here are some pointers for anyone filing an objection.

1. If you would like to have someone represent you, arrange this before you send in the objection form. Once you file an objection, the WCB will generally give you only 21 days to find a representative. If after the 21 days you need more time, your only option will be to withdraw the objection and resume it once you are ready.
2. Read the claim file and clarify issues or decisions you do not understand with your adjudicator or case-worker.
3. Know what your position is, especially when heading into mediation. Remember, mediation runs on a 60-day clock. If you are not ready before you start the clock by sending in the objection form, you might not get the time you need to research and develop your position.
4. Send any additional information that supports your case to the WCB as soon as it becomes available. This is the key to avoiding unnecessary delays.

For more information on the new appeals system, call the Appeals Branch at (416) 344-1014, or 1-800-387-0773.

#### g to the type of issue involved.



# You asked us

The WCB's three policy branches (benefits, medical & occupational disease, and revenue) regularly receive calls from stakeholders with questions about workers' compensation. In each issue of **Policy Report**, we will try to answer some of the most commonly asked questions.

**Q.** *I am in receipt of temporary total disability benefits from the WCB and I would like to apply for parental leave from my employer because my wife just gave birth. Can the WCB suspend my benefits so I can receive parental leave since it will provide me with more money?*

**A.** No. If you continue to be totally disabled because of your work injury, s. 37(1) of the *Act* requires the WCB to pay temporary total disability benefits for as long as the total disability lasts. If your employer decides to pay you directly (paying advances) while you are off on compensation, the WCB will reimburse your employer, but only up to 90% of your pre-injury net average earnings. You may want to discuss this situation with your employer to see if any privileges/conditions associated with parental leave could be provided to you even though you continue to receive benefits from the WCB.

## Clarification

Further to the item on turning 65 that appeared in the April 1996 issue of *Policy Report*, workers who were injured on or after January 2, 1990 and are over 65, are only entitled to temporary benefits up to the date they reach maximum medical rehabilitation (MMR). Even though temporary benefits stop at this point, these workers are still entitled to be considered for a non-economic loss (NEL) benefit. For more information please see OPM documents 05-01-13 and 05-03-11.

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# POLICY REPORT



Workers'  
Compensation  
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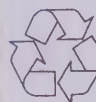
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# POLICY REPORT

The Appeals Process.....1

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Volume 9, Number 3 June 1996

A publication of the Workers' Compensation Board of Ontario

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The mediator then calls the parties to tell them about the dispute and explain the mediation process, emphasizing that it is confidential and voluntary. Any of the parties—the worker, employer, or WCB decision-maker—may turn down the WCB's offer to mediate, in which case the dispute goes directly to a hearing before a reinstatement officer.

### Step 2 - Mediating

The mediator's next step is to define the issue in dispute. To do this, the mediator talks to the parties: trying to fill in gaps in their knowledge that might be contributing to the dispute; and giving them insight into each other's position, and WCB policy.

The mediator encourages free discussion, looking for ways to resolve the dispute, and suggesting possible solutions to the parties. Ideally, the process concludes with an agreement. Otherwise, the mediator stops the discussion approximately 21 days after it started. Where necessary, the WCB may decide to continue the mediation beyond 21 days.

### Step 3 - Decision-making

When mediation fails to resolve the issue, the parties may either

- ask the mediator to make the final decision of the WCB, (to do so,

the parties must waive their right to keep the information they have shared with the mediator confidential, so that the mediator's decision can be added to the claim file), or

- ask that the decision be rendered by a reinstatement officer, after an oral hearing.

### Outcomes

If an objecting party withdraws from mediation but later chooses to dispute the issue again, the WCB will not provide further mediation and will treat the operating area's decision as the final decision of the WCB. Other outcomes—like a mediated settlement, a mediator's decision, or a reinstatement officer's decision—all represent final decisions of the WCB.

### The entitlement stream

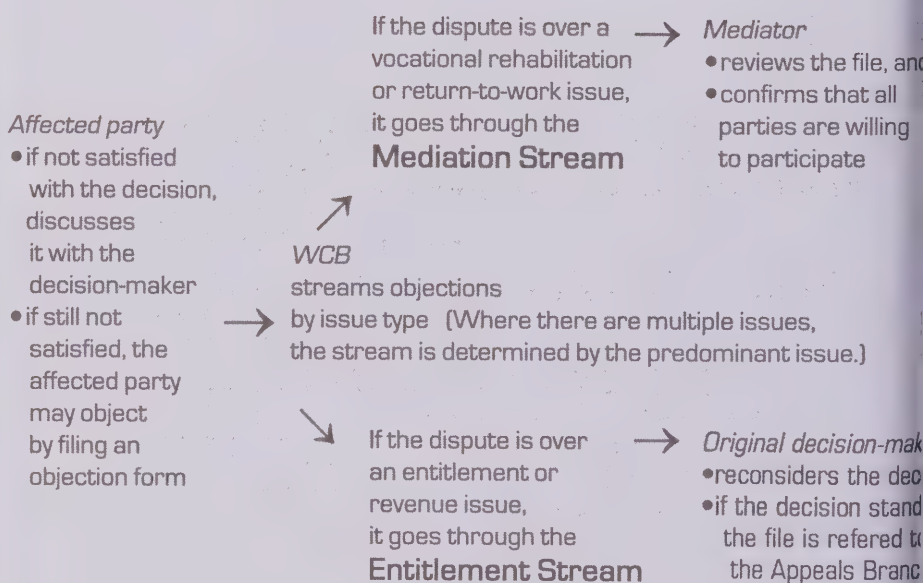
In entitlement cases, the WCB directs the objection form and any new information received, to the decision-maker, before sending it on to the Appeals Branch.

The decision-maker **reconsiders** the original decision and addresses new issues, if any have come up. If the decision-maker does not change the decision, a manager does a final check to ensure all enquires have been made and there are no outstanding issues, before referring the objection to the access area (see box p.1) and the Appeals Branch.

Appeals Branch staff then log the objection and, once it reaches the top of the case inventory, assign it to an appeals officer. Each appeals officer is responsible for cases from a particular part of the province. This encourages good working relationships with the employer and worker communities in their area, and allows them to learn about local industries.

Appeals officers perform a single comprehensive review of a file, which replaces the two tiers of the old appeals process: the paper review and the oral hearing.

## The WCB streams objections





This one review can take whatever form best suits the case at hand. After looking into the case and discussing it with the parties, appeals officers may ask for written submissions, or they may find that further enquiries are necessary. (Any new information they gather is added to the claim file and shared with the parties.)

As often as possible, appeals officers try to resolve disputes by making decisions in light of the information on file and any new information or submissions they receive. They reserve oral hearings for cases hinging on complex factual issues or personal credibility. However, appeals officers will hold an oral hearing at the request of either party.

#### Outcome

Appeals officers address the issue in dispute, and any additional issues that need to be addressed to achieve a full and sensible outcome. For example: an appeals officer who grants initial

entitlement may also decide on the nature, level, and duration of benefits payable up to the time of the decision.

Like mediation outcomes, appeals officers' decisions represent the WCB's final decision on the issue under review, and can only be appealed to the Workers' Compensation Appeals Tribunal (WCAT) — an external body which provides the final review of WCB decisions.

#### Objections involving claims entitlement and VR

Some objections involve both claims entitlement and VR issues. These cases generally go through the entitlement stream, rather than the mediation stream. However, these cases will go through mediation if

- the worker might return to work with the accident employer, or
- the VR issue involved does not depend on the entitlement issue.

#### Objections to non-economic loss (NEL) decisions

In most cases, NEL objections are not reviewed by appeals officers but by NEL appeal decision-makers. Like appeals officers, their decisions are the final decisions of the WCB, which can only be appealed to WCAT. Appeals officers only handle NEL appeals if the NEL is among other issues under review, or if the NEL was rated 0%.

#### Consider this before you object

Here are some pointers for anyone filing an objection.

1. If you would like to have someone represent you, arrange this before you send in the objection form. Once you file an objection, the WCB will generally give you only 21 days to find a representative. If after the 21 days you need more time, your only option will be to withdraw the objection and resume it once you are ready.

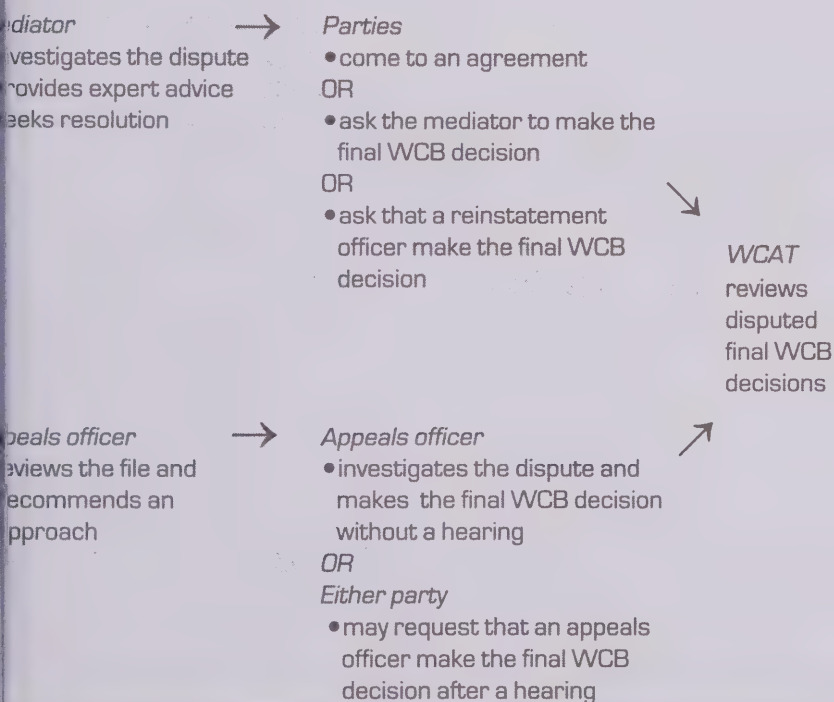
2. Read the claim file and clarify issues or decisions you do not understand with your adjudicator or caseworker.

3. Know what your position is, especially when heading into mediation. Remember, mediation runs on a 60-day clock. If you are not ready before you start the clock by sending in the objection form, you might not get the time you need to research and develop your position.

4. Send any additional information that supports your case to the WCB as soon as it becomes available. This is the key to avoiding unnecessary delays.

For more information on the new appeals system, call the Appeals Branch at (416) 344-1014, or 1-800-387-0773.

#### g to the type of issue involved.



# You asked us

The WCB's three policy branches (benefits, medical & occupational disease, and revenue) regularly receive calls from stakeholders with questions about workers' compensation. In each issue of **Policy Report**, we will try to answer some of the most commonly asked questions.

**Q.** *I am in receipt of temporary total disability benefits from the WCB and I would like to apply for parental leave from my employer because my wife just gave birth. Can the WCB suspend my benefits so I can receive parental leave since it will provide me with more money?*

**A.** No. If you continue to be totally disabled because of your work injury, s. 37(1) of the *Act* requires the WCB to pay temporary total disability benefits for as long as the total disability lasts. If your employer decides to pay you directly (paying advances) while you are off on compensation, the WCB will reimburse your employer, but only up to 90% of your pre-injury net average earnings. You may want to discuss this situation with your employer to see if any privileges/conditions associated with parental leave could be provided to you even though you continue to receive benefits from the WCB.

## Clarification

Further to the item on turning 65 that appeared in the April 1996 issue of *Policy Report*, workers who were injured on or after January 2, 1990 and are over 65, are only entitled to temporary benefits up to the date they reach maximum medical rehabilitation (MMR). Even though temporary benefits stop at this point, these workers are still entitled to be considered for a non-economic loss (NEL) benefit. For more information please see OPM documents 05-01-13 and 05-03-11.

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# POLICY REPORT



Workers'  
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# POLICY REPORT

A publication of the Workers' Compensation Board of Ontario

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Volume 9, Number 2

April 1996

## Workers' Retirement Pension

Compensating workers whose accidents occurred on or after January 2, 1990, for loss of retirement income

When we think of retirement, one question immediately comes to mind: "Am I going to have enough income to meet my needs when I am 65?" Consider the concern of a worker who, at age 55, suffers a work-related injury or develops an occupational disease resulting in a permanent impairment and loss of income. Will the worker get a retirement pension from the WCB? How much? And for how long?

If you think the worker *will* get a WCB retirement pension at age 65, you may be right!

On January 2, 1990, amendments to the *Act* replaced lifetime pensions for permanent disability with a dual award system: Non-Economic Loss (NEL)—which compensates workers who suffer permanent impairment as the result of a work-related accident and; Future Economic Loss (FEL)—which compensates workers who experience a wage loss due to a permanent impairment or who are temporarily disabled for at least 12 continuous months. Entitlement to FEL benefits ceases when a worker turns 65.

A worker who has received a FEL benefit is entitled to receive benefits for loss of retirement income upon reaching age 65. The *Act* stipulates that the WCB set aside additional funds equal to 10 % of every FEL payment made to a worker. The WCB puts these monies into a special investment fund until the worker reaches age 65, or dies, whichever occurs first.

The money set aside for each worker, plus the investment income it accumulates, is referred to as the worker's "account balance". The *Act* states that if, when the worker reaches the age of 65, the amount of money in the account is **insufficient** to generate an annual pension of \$1,000,\* the WCB pays the worker the account balance in one lump sum.

The workers' retirement pension is a supplement to other retirement income, such as company pensions, Old Age Security (OAS) benefits, Canada Pension Plan (CPP), and Registered Retirement Savings Plan (RRSP). It does not replace any other employment pension, and entitlement is not affected by any other source of retirement income.

However, if, when the worker reaches age 65, the account balance is **sufficient** to generate an annual pension of \$1,000 or more, the worker is required to choose one of several payment schemes and indexing factors.

How much a worker gets, and for how long, depend on the payment scheme the worker chooses and the account balance, among other factors.

### Payment schemes

Payment schemes allow workers to decide how to distribute their account balance over their lifetime, and after their death. Although the monthly amount paid to the worker is different for each scheme, in the long term, each payment scheme is essentially of equal value.

There are five payment schemes from among which the worker may choose:

1. Joint and survivor annuity
2. Life annuity
3. Life annuity with return of account balance
4. Life annuity with a fixed guarantee period
5. Life annuity with a guarantee to age 90.

The WCB uses the following **common factors** to help determine a worker's monthly retirement pension:

- worker's account balance at age 65
- the life expectancy for workers at age 65
- the level of interest rates when the worker turns 65, and
- the indexing factor chosen.

\* The indexed 1996 amount is \$1,142.16.



## An overview of the 5 payment schemes

### Joint and survivor annuity

If the worker has a spouse, the WCB pays a joint and survivor annuity unless both parties waive this option.

A worker who qualifies for this scheme is paid monthly—from age 65 until death. If the worker is survived by a spouse, the spouse is paid monthly at a rate equal to 60%, 75%, or 100% of the worker's monthly payment, until death.

Using the WCB's Retirement Pension Election Form, the worker chooses the level of payment to be made to the spouse. Monthly payments are based on the *common factors*; the life expectancy of the worker's spouse; and the level of payment chosen for the spouse.

#### Example\*:

Jasmine, a lab technician, has a \$20,000 account balance. She is married. If she sets the level of her spouse's payment at 60% of her own, Jasmine's payment is \$160.22, monthly. If her spouse survives her, he will receive \$96.13 per month.

If Jasmine sets the level of her spouse's payment at 75%, she will receive \$155.49 monthly; and her spouse will receive \$116.62, monthly, if he survives her. If the level is set at 100%, the two payments will even out at \$148.19 per month.

Workers who do not have a spouse may choose from among the 4 other payment schemes. If they do not make a choice, they are paid a life annuity with a fixed guarantee period of 10 years.

### Life annuity

Here, the WCB pays the worker a monthly retirement pension from age 65, but discontinues payment when the worker dies. Under this scheme, monthly payments are based on the *common factors* alone.

If Jasmine were single, or if she and her spouse signed a WCB Waiver of Joint and Survivor Annuity and Jasmine then chose a life annuity, her monthly payment would be \$182.44. This is higher than under the joint and survivor scheme because the anticipated payment period is shorter than it would be for both her and her spouse.

### Life annuity with return of account balance

Under this scheme, the worker is paid from age 65, onwards. When the worker dies, the WCB calculates the difference between the original account balance and the amount paid out to the worker, and pays the difference to the worker's estate as a lump sum.

Monthly payments are based on the *common factors*. The probability that the full account balance will be paid out is also factored into the calculation.

If Jasmine elects this option, she will be paid \$167.75 per month, up to her death. If she dies in the month she turns 70, she will have received \$10,065. The \$9,935 remaining in her account is paid to her estate.

### Life annuity with a fixed guarantee period

This scheme provides monthly payments from age 65 until the worker's death. By choosing a guarantee period of 5, 10, or 15 years, workers ensure that a payment will be made to their estate should they die before the guarantee period ends. The estate receives a lump sum equal to the value of the payments due to the worker for the remainder of the guarantee period. Workers who live beyond the guarantee period continue to receive payments until their death, but when they die no payment is made to their estate.

Monthly payments are based on the *common factors* as well as on the length of the guarantee period. The longer the guarantee period, the lower the monthly payments.

If Jasmine chooses a life annuity with a guarantee period of

- 5 years, she receives	\$178.63 per month
- 10 years	\$169.51 per month
- 15 years	\$158.32 per month.

### Life annuity with a guarantee to age 90

This scheme provides monthly payments from age 65, until the worker dies. If this happens before age 90, the value of the remaining payments is paid to the worker's estate as a lump sum. Workers who live beyond age 90 continue to receive monthly payments, but no payment is made to their estate when they die.

Under this scheme, Jasmine would receive \$137.75 per month.

### Choosing an indexing factor

Workers may choose to have their pensions indexed by 1%, 2%, or 3%, annually—or not at all. If a worker is survived by a spouse who is entitled to a pension, the indexing factor applied to the worker's pension also applies to the surviving spouse's pension. The choice of indexing factors allows workers to affect how their pension is distributed over the payment period.

Indexing does not increase the overall value of the pension. It only increases the amount of the later payments by decreasing the amount of the earlier ones.

\* In the examples, values are for illustration only. They assume no indexing.



# You asked us

The WCB's three policy branches (benefits, medical & occupational disease, and revenue) regularly receive calls from stakeholders with questions about workers' compensation.

In each issue of **Policy Report**, we will try to answer some of the most commonly asked questions.

## What effect will turning 65 have on my compensation benefits?

Your 65th birthday may have an effect on compensation benefits, depending on the type of benefits you are receiving.

Turning 65 has no effect on temporary **total** disability benefits. As long as workers are temporarily totally disabled, they are entitled to full benefits.

Workers who are 65 or older, and who are partially disabled, are entitled to temporary **partial** disability benefits when:

- they return to modified work at a wage loss, or
- they co-operate in, or are available for, a medical or vocational rehabilitation program that would aid in getting them back to work, or
- they are available for work that is suitable for their capabilities.

If workers were injured before January 2, 1990, turning 65 has no effect on their entitlement to **permanent** disability benefits, since these benefits are paid for the rest of their lives. However, they may not be entitled to full supplementary benefits if the WCB determines that they would not benefit from a vocational rehabilitation program. If this is the case, they could be entitled to partial supplementary benefits depending on their entitlement to Old Age Security (OAS) payments. For more information about supplements, see OPM documents 05-03-06 and 05-03-09.

If workers were injured on or after January 2, 1990, they would not be entitled to **Future Economic Loss** (FEL) benefits once they turned 65. If they were receiving FEL benefits when they turned 65, FEL benefits would stop and they could receive retirement payments (see article on page 1). If they turned 65 before FEL benefits could be determined, they would only be entitled to a determination of a **Non-Economic Loss** (NEL) benefit. For more information about FEL and NEL benefits, see the OPM, sections 05-05 and 05-06.

I understand that some types of businesses, or industries, are covered automatically under the *Act*, and others are not. How does this work?

### Compulsory coverage

All industries listed in Regulation 1102, (found at the back of the *Act*), are covered automatically by workers' compensation.

### Coverage by application

Employers who operate in an industry which is not listed in Regulation 1102, can apply for workers' compensation coverage. See OPM document 08-02-02.

### Personal coverage

Some individuals are not automatically considered to be "workers" under the *Act*, and therefore are not covered even when their company has compulsory coverage or has requested coverage by application. These individuals include employers themselves, independent operators, executive officers, and sole proprietors of a business. To be covered by workers' compensation, they must request personal coverage. See OPM document 08-02-03.

## Who is the employer when an insurance company places an individual, receiving insurance benefits, with a company for work-hardening or training?

When an insurance company places one of their clients with an employer for work-hardening or training, the employer and not the insurance company, assumes WCB responsibility for the client, who becomes a worker" under the *Act*. (As long as the employer has coverage under the *Act*.)

Should an accident occur while the client is working, the employer is required to report the injury to the WCB. If a claim is accepted, the costs will appear on that employer's accident cost statement, even though the employer was not paying the worker. For more information on unpaid training participants, see OPM documents: 01-02-13; 05-02-02; 08-04-08; 05-02-06 and 07-05-02.

## Some frequently asked questions about retirement pensions

### What happens if a worker who is entitled to a retirement pension dies before reaching age 65?

In these cases, the WCB pays a "pre-retirement death benefit" equal to the worker's account balance to the surviving spouse or dependents, in this order:

1. the surviving spouse,
2. dependent children, in equal shares,
3. other dependants, in equal shares,
4. the worker's estate.

Death benefits are usually paid as a lump sum. If a surviving spouse qualifies for this benefit, and the account balance generates an annual pension of \$1,000, or more, the spouse may choose to receive the benefit as a life annuity, in which case the spouse must send a signed request to the WCB.

### What happens if the WCB retroactively increases the FEL benefit?

If the WCB retroactively increases a FEL benefit after paying a retirement pension or pre-retirement death benefit, the WCB makes the necessary adjustments to the payment.

### Can overpayments created elsewhere in a claim be collected from a retirement pension?

Yes, but only when the retirement pension or death benefit becomes payable i.e., the worker reaches age 65, or dies.

### Can a spouse or dependant receive both survivor benefits (for work-related deaths), and a retirement pension, under the same claim?

No. Under the *Act*, anyone receiving survivor benefits is not entitled to a retirement pension in the same claim.

For more information on the retirement pension, see *Ontario Regulation 715/94*, s.44 (of the *Act*), and OPM document 05-07-02. You may also contact the WCB's Injured Worker Pension Section by calling (416) 344-4306, or toll free at 1-800-387-5540, extension 4306. ❖

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# POLICY REPORT

A publication of the Workers' Compensation Board of Ontario

## Special Bill 15 issue!

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Volume 9, Number 4

October 1996

As first reported in *Policy Report* Volume 9, Number 1 (February 1996), Bill 15, *An Act to amend the Workers' Compensation Act and the Occupational Health and Safety Act*, received Royal Assent on December 14, 1995.

Bill 15 introduced the concept of "material change" to the *Workers' Compensation Act* (the *Act*). It is important to understand the concept of material change, as well as the policies. As you will see after reading this issue of *Policy Report*, it is the failure to report a material change that can lead to a worker or employer being in debt to the WCB, or being fined for committing an offence.

## Reporting material change

The WCB has always expected workers and employers to report changes related to their claims and obligations — but the types of information to report and when to report was unclear. However, effective January 1, 1997, Bill 15 makes the reporting requirement explicit, and backs it up with penalties for the **wilful** failure to report.

### What is a material change in circumstances?

For any persons (workers, survivors, dependants) with entitlement to WCB benefits or services, a material change is **any** change that affects their entitlement, e.g., changes in the work-related medical condition, e.g., the worker becomes capable of modified work that affect availability for work, or participation in WCB-sponsored medical or VR programs, e.g., non-work-related medical conditions, or the worker moves out of Ontario, or is imprisoned in earnings or other income, e.g., a worker receiving total disability benefits returns to part-time work, or begins to receive CPP/QPP benefits for the work-related impairment that affect a dependant child who reaches age 19 and does not continue to attend school.

For employers, a material change is **any** change that may affect their obligations under the *Act*, e.g., changes in business activity assessable payroll, personal coverage earnings

- business name and/or address
- ownership
- legal affiliations with other companies
- ongoing operations, e.g., dissolutions, bankruptcy.

### Reporting a material change

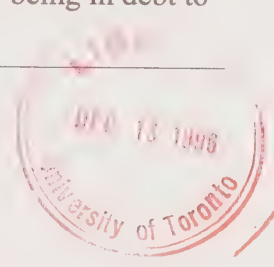
If you are not sure if a change or new information warrants reporting, contact the WCB.

Changes should be reported as soon as they occur, but no later than 10 calendar days after the change (including the date of the change). For example, workers should notify the WCB as soon as possible of a planned return-to-work date.

The required information must be communicated to the appropriate WCB decision-maker by telephone, or written notice, hand delivered, mailed, sent by courier, or faxed to a WCB office.

### When is a failure to report considered wilful?

Unless individuals or employers can demonstrate that they had no knowledge of the change, the WCB presumes that a failure to report is intentional and deliberate, and thus wilful. Neglecting or forgetting to inform the WCB is not a valid reason for failing to report. ☐



# Benefit-related

Outstanding overpayments represent a significant expense in the workers' compensation system, one that neither the WCB nor any other business can afford. As a result of this, and the new provisions of Bill 15, the WCB developed a new policy regarding benefit-related debt recovery.

The new policy replaces the current "Recovery of Overpayments" document dated 1992. Effective January 1, 1997, it applies to all benefit-related debts due and owing to the WCB.

Worker, survivor, dependant, and employer debts are usually a result of

- entitlement changes, e.g., entitlement is amended or revoked on review, objection, or appeal
- material change, e.g., benefits are provided because of, or based on, misinformation
- processing errors.

The WCB does not make a distinction between debts created as the result of administrative error and those resulting from reversals in entitlement.

## Statutory Provisions

Before Bill 15, the WCB did not have any express statutory authority to collect debts. Nonetheless, it was accepted that this power was implicit in sections 73(1) and 101 of the *Act*.

### Bill 15

The following sections have been added to the *Act* as a result of Bill 15. The new statutory provisions specify that an overpayment is a debt due and owing to the WCB at the time the overpayment is made, and formally give the WCB the authority to pursue recovery action.

s.21.1(1) An overpayment made by the Board to a person who receives compensation under the *Act* is a debt due and owing to the Board at the time the overpayment is made.

s.21.1(2) The amount of the overpayment is as determined by the Board.

**Benefit-related debt** - Any payment made by the WCB in respect of, or to: a worker, survivor, dependant, employer, or agency, that exceeds the entitlement conferred by the *Act*.

s.66(1) The Board may deduct from money payable to a person by the Board all or part of a debt due to the Board from the person.

s.66(2) The Board may pursue such other remedies as it considers appropriate to recover a debt due to it.

s.130.1(1) An overpayment made by the Board to an employer is a debt due and owing to the Board at the time the overpayment is made.

s.130.1(2) The amount of the overpayment is as determined by the Board.

s.130.1(3) In the case of an employer in an industry included in Schedule 1, the Board has the same powers... for enforcing payment of an overpayment as it has for payment of assessments. In the case of an employer in an industry included in Schedule 2, the Board may add the amount of an overpayment to the amount payable by the employer under subsection 137(1).

## Notification

To pursue recovery of debts resulting from payments made before January 1, 1997, the WCB must notify the debtor within **3 years** of the date the debt is considered due and owing to the WCB (i.e., the date the payment was made that should not have been made).

The only **exception** to the 3 year guide would be where a debtor failed to report a material change in circumstances (see article on page 1).

For debts resulting from payments made on or after January 1, 1997, there is no time limit on notification.

## Objection/appeal rights Entitlement decisions

Debtors have the right to appeal any entitlement decision both internally (Appeals Branch) and externally (WCAT).



# Debt recovery

## Debt decisions

As a result of changes in the Act effective December 14, 1995 (the date of royal assent of Bill 15), debtor's objection/appeal rights concerning

- the determination that a debt exists
- the amount of a debt, or
- any issues related to debt recovery

differ according to the date of the payment that is subsequently determined to be a debt due and owing to the WCB.

For debts resulting from payments made

- **before December 14, 1995**, debtors have the right to appeal debt decisions both internally (Appeals Branch) and externally (WCAT).
- **on or after December 14, 1995 through December 31, 1996, inclusive**, debtors may only appeal debt decisions internally (Appeals Branch).
- **on or after January 1, 1997**, debtors do not have any internal or external appeal rights.

## Suspension of recovery during objection/appeal

For objections/appeals resulting from payments made

- **on or before December 31, 1996**, no debt recovery action is taken throughout the objection/appeal process.
- **on or after January 1, 1997**, WCB debt recovery action is **continued** throughout the objection/appeal process.

## Time limit on recovery efforts

There is no time limit placed on the duration of a debt recovery plan.

## Recovery methods

The WCB makes every attempt to recover debts. This includes

- accepting full re-payment from debtors
- negotiating repayment plans
- deducting the debt from any money payable by the WCB to the debtor.

If these efforts fail, the WCB may consider taking court action.

If court action is initiated, s.128(1) of the *Courts of Justice Act* allows the WCB to charge interest on outstanding debts.

With respect to taking **court action**, under the *Limitation Act*, the WCB has 20 years to assert its rights to recover a debt through the courts.

## Exception

In cases of **severe, long-term financial hardship**, the WCB may exercise its discretion to reduce or eliminate the debt if re-paying it will compromise the debtor's ability to maintain the necessities of life, e.g., food, shelter, and transportation to work.

A WCB decision not to pursue the debt due to severe, long-term financial hardship is meant to address the low wage earner with limited assets who is likely to continue to be in an extremely difficult financial position for some time into the future. The decision-maker must determine that the debtor has no significant assets and, in both the long and short term, is either unable or only marginally able to meet ongoing financial responsibilities and obligations.

**Temporary inability to repay a debt** does not constitute financial hardship. These situations are addressed by flexible recovery methods.

## Material change, offences, or fraudulent acts

Debts created through deception, e.g., failure to report material change, or intentionally receiving and keeping money to which there is no entitlement, is addressed in conjunction with the "Offences and Penalties" and "Material Change in Circumstances" policies (see accompanying articles). □

# Offences and Penalties

Effective January 1, 1997, the WCB will take action every time an offence or a fraudulent activity is discovered. This supports the primary objective of Bill 15: to ensure the financial viability of the workers' compensation system.

There are four ways the WCB can take action:

- levy an administrative penalty under the *Act*
- prosecute an offence under the *Provincial Offences Act*
- refer cases of fraud to the police and the Crown for charging and prosecuting under the *Criminal Code*
- initiate civil action for the recovery of money or property.

Bill 15 makes changes to the statutory provisions governing **offences** and **penalties** by:

- consolidating and renumbering all existing provincial offences under Part V of the *Act*
- adding 4 new quasi-fraud offences, and
- raising the maximum fines that the court can levy.

## Offences

**Employers** who fund the workers' compensation system, or **persons**, including workers and their survivors who receive WCB benefits/services, and suppliers of goods and services, can be charged with an offence.

## Penalties

Before Bill 15, maximum fines varied for each offence. Now, the amount of a fine depends on whether the offence is committed by a person or by a corporate entity.

If convicted of an offence under the *Act*,

- a **person** is liable to a fine not exceeding \$25,000 or to imprisonment not exceeding 6 months, or both
- a **corporation** is liable to a fine not exceeding \$100,000.

In some cases, both the **person** (a director or an officer) in the corporation—if they knowingly authorized, permitted, or agreed to the commission of an offence—and the **corporation**, itself, can be prosecuted and convicted for an offence.

## Time limit

Under sections 152 to 160, the WCB has 6 months to lay charges under the *Provincial Offences Act*, counting from the date the offence was committed or is alleged to have been committed.

Under s.161, if a case is to be prosecuted, proceedings will begin not more than 2 years after the date on which the most recent act or omission came to the attention of the WCB.

**Employers** may be prosecuted for contravening any of the following statutory provisions.

Section	Formerly	Description of offence
152	20(2)	deducting workers' compensation expenses from workers' wages
153	50(9)	directly/indirectly collecting, receiving, retaining contributions from workers for health care expenses
154(1)	63(4)	failing to comply with rules of an approved accident prevention association
155(1)	71(8)	disclosing medical information about a particular worker or case
156	New	failing to register within 10 days after becoming an employer, in accordance with s.108(1)
157	109(6)	failing to submit statements of earnings or any other information the WCB may require
158(1)	111(3)	failing to allow examination of payroll records by authorized persons to ensure wages are reported correctly
158(2)	113(2)	failing to allow inspection of premises by authorized persons
159	130(3)	failing to pay or give security for sufficient funds to pay assessments, in the case of an industry temporarily carried on
160	133(2)	failing to report accidents on time
161(3)	New	wilfully failing to inform WCB within 10 days of material change relating to obligations under the <i>Act</i> .

**Persons** may be prosecuted for contravening any of the following:

- 161(1) knowingly making a false statement or representation to WCB relating to benefit entitlement
- 161(2) wilfully failing to inform WCB within 10 days of material change relating to benefit entitlement
- 161(4) knowingly making false or misleading statement or representation to WCB to obtain payment for goods or services (supplier) ☐



# Bill 15 Q&A

Here are some questions and answers to help you understand the Bill 15 material covered in this issue of *Policy Report*.

## Material Change in Circumstances

All material change in circumstances related to

- an employer's obligations under the *Act*, and
- a person's (worker, survivor, dependant) entitlement to benefits or services under the *Act*

must be reported to the WCB within 10 calendar days of the occurrence.

**Q.** I injured my leg at work. My doctor expects that it will be at least four weeks before I can return to my regular job as a sales associate in a department store because I am not able to stand or walk for prolonged periods of time.

Between now and when I am fit to return to my regular job, I would like to do part-time telephone sales work from home. Should I tell my claims adjudicator?

**A.** Yes.

Accepting a part-time job provides an indication of your level of disability and your ability/willingness to perform modified work. Perhaps your employer could offer you modified work, at little or no wage loss, until you are medically able to resume your pre-injury job. If so, you could return to work and your WCB benefits would be adjusted accordingly.

**Q.** I own a company that assembles small marine pumps. To improve the quality of our end-product, I have decided to manufacture some of the components 'in house.' This will require that I purchase machine tooling equipment and retrain some of my employees to do this work because I do not want to hire new employees.

The number of employees will not increase, and the manufacturing of the pump components complements my existing operation. Should I advise the WCB of these changes?

**A.** Yes.

The manufacturing of pump components may have a higher risk factor which should be reflected in your WCB assessment. Also, this is a change in your business activity that may change your current classification unit.

## Benefit-Related Debt Recovery

A benefit-related debt is a debt resulting from any payment made by the WCB that should not have been made. To pursue recovery of debts resulting from payments made before January 1, 1997, the WCB must notify the debtor **within 3 years of the date the debt is considered due and owing** to the WCB. The date the payment was made, that should not have been made, is the date from which the debt is considered due and owing.

For debts resulting from payments made on or after January 1, 1997, **the 3 year rule does not apply.**

**Q.** I registered a claim for WCB benefits on December 1, 1991, and received biweekly temporary total disability benefits from December 1, 1991 through December 10, 1992. My claim was reviewed on February 3, 1996, and the WCB determined that I did not have entitlement to those benefits.

Do I have to repay the WCB?

**A.** No.

Applying the 3-year rule for debts resulting from payments made before January 1, 1997, you do not have to repay the WCB because:

- the payments you received were made prior to January 1, 1997. In your case, applying the 3 year rule, the WCB cannot pursue debt recovery for any payments made before February 3, 1993 (3 years before the February 3, 1996 decision), **and**
- the WCB did not notify you within 3 years of making the payments.

**Q.** I was injured at work on December 20, 1995. Since then, I have returned to working part-time. I have received full WCB benefits throughout this time.

Recently, the WCB notified me that I was not entitled to full benefits because I was receiving wages for part-time work. This has resulted in a debt due and owing to the WCB. Also, because I did not notify the WCB that I had returned to part-time work and was in receipt of

*continued on page 6*

## Bill 15 Q&A (cont'd)

wages, will the WCB determine that I failed to report a "material change in circumstances" and levy a penalty?

A. Yes.

Because the payments were made before January 1, 1997, the 3-year rule applies. In your case, the WCB will contact you to make repayment arrangements. The WCB will also make a determination concerning what (if any) action should be taken regarding your failure to report a "material change in circumstances." □

## Consultation invited

The Occupational Disease Panel recently submitted the following reports to the WCB:

- *Addendum to IDSP Report No. 12 Report to the Workers' Compensation Board on Lung Cancer in the Hardrock Mining Industry*
- *Report to the Workers' Compensation Board on Stomach Cancer in Ontario Gold Miners*
- *Report to the Workers' Compensation Board on the health effects of occupational exposure to fluids used for machining and lubricating metal in manufacturing: Cancer of the esophagus*

Copies of these reports are available from:

Occupational Disease Panel  
69 Yonge Street, Suite 1004  
Toronto, Ontario M5E 1K3  
Tel: (416) 327-4156

If you would like to provide the WCB with comments, briefs, or submissions concerning the findings and recommendations, send them to:

Ms. Linda Angove  
Secretary to the Board  
Workers' Compensation Board  
200 Front Street West, 17th floor  
Toronto, Ontario M5V 3J1

The submission deadline for the first report is November 27, 1996. The deadline for the second and third reports is January 17, 1997. □

# POLICY REPORT



Workers'  
Compensation  
Board

Commission  
des accidents  
du travail

*Policy Report* subscriptions are free. *Policy Report* is published under the authority and direction of the Benefits Policy Branch of the Workers' Compensation Board. If there is any conflict between information in this publication and the *Workers' Compensation Act* or WCB approved policy documents, the Act or the approved policy governs.

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# Calling the WCB

*When you call the WCB, reach the staff you need to speak to quickly by dialing their area directly, using the guide below.*

**Enquiring about a claim** - Claims are administered in integrated service units (ISUs), or regional offices. The last digit of a claim number, following the dash, indicates where it is handled.

## Claim numbers ending in

ISUs .....	local # .....	toll free #
- 1, Central Ontario East .....	(416) 344-1001 .....	1-800-263-8877
- 2, Toronto East .....	(416) 344-1002 .....	1-800-387-0066
- 3, Toronto North .....	(416) 344-1003 .....	1-800-387-8607
- 4, Construction .....	(416) 344-1004 .....	1-800-387-0080
- 5, Central Ontario West .....	(416) 344-1005 .....	1-800-387-0025
- 6, Toronto West .....	(416) 344-1006 .....	1-800-387-0062
- 7, Central Ontario South .....	(416) 344-1007 .....	1-800-387-0068
- 8, Toronto South .....	(416) 344-1008 .....	1-800-387-0064
- Z, Complex Cases (Injuries) re: FEL and NEL ..	(416) 344-1009 .....	1-800-465-5538
- O, Complex Cases (Diseases) .....	(416) 344-1010 .....	1-800-465-9646

### Note:

Most of the toll free numbers below can be reached from anywhere in Ontario. Those which cannot, have the area(s) or area code(s) from which they can be reached in brackets after the number.

## Regional Offices

- H, - A, or - B, Hamilton .....	(905) 523-1800 .....	1-800-263-8488	(416,905,519,613 & 705)
- L, London .....	(519) 663-2331 .....	1-800-265-4752	
- P, - K, or -Q, Ottawa .....	(613) 238-7851 .....	1-800-267-9601	(Ontario and Quebec)
- S, Sudbury .....	(705) 675-9301 .....	1-800-461-3350	(705 & 819)
- U, Thunder Bay .....	(807) 343-1710 .....	1-800-465-3934	(204, 705, & 807)
- W, Windsor .....	(519) 966-0660 .....	1-800-265-7380	

## Enquiring about an account

• registering a business, reporting, or paying an assessment .....	(416) 344-1013 .....	1-800-387-8638	
• Accident Cost Statements .....	(416) 344-1016 .....	1-800-663-6639	
• audits .....	(416) 344-3628 .....	1-800-387-5674	
• Clearance Certificates .....	(416) 344-1012 .....	1-800-387-8638	
• collections .....	(905) 521-4404 .....	1-800-268-0929	
		1-800-268-6045	(Montreal)
• experience rating .....	(416) 344-3456 .....	1-800-668-4864	

## Area Offices

Kingston .....	(613) 544-9682 .....	1-800-267-9461	(613)
Kitchener-Waterloo .....	(519) 576-4130 .....	1-800-265-2570	
North Bay .....	(705) 472-5200 .....	1-800-461-9521	(Ontario & 819)
Sault Ste. Marie .....	(705) 942-3002 .....	1-800-461-6005	(705 & 807)
St. Catharines .....	(905) 687-8622 .....	1-800-263-2484	
Timmins .....	(705) 267-6427 .....	1-800-461-9856	(705 & 819)

If your claim number ends in -T, or you cannot find a number on this list, call (416) 344-1000, or 1-800-387-5540.

*Please see over.*

## To find out about ..... call 416 .....or, toll free

- the appeals/mediation process,  
or an appeal underway (Appeals Branch) ..... 344-1014 ..... 1-800-387-0773
- Form 7s (*Employer's Report of Injury/Disease*)
  - to submit by fax ...344-4684 ..... 344-3796 ..... 1-800-387-0750\*
  - to get approval of a facsimile ..... 344-4448 ..... 1-800-387-0750\*
- health care agency
  - account processing ..... 344-1019 ..... 1-800-387-0750\*
  - registration ..... 344-2937/6/5 ..... 1-800-387-0750\*
- health and safety practices & WCB incentives,  
or workplace first aid (Workwell) ..... 344-3472 ..... 1-800-668-4864
- health and safety training  
(Workplace Health and Safety Agency) ..... 1-800-268-2378
- the *Occupational Health and Safety Act*  
(Ministry of Labour) ..... 326-7770 ..... 1-800-268-8013
- third-party elections, transfers of costs, support deductions, assignment of no-fault  
insurance benefits, or the *Freedom of Information and Protection of Privacy Act* (Legal Branch)  
344-2953 ..... 1-800-387-5540

## To get ..... call 416 .....or, toll free

- 'access' i.e., claim file copies (call the ISU or office for your area)
- a copy of the *Act* (Publications Ontario) ..... 326-5300 ..... 1-800-668-9938
- brochures, reports, etc. (Communications) .. 344-4200 ..... 1-800-387-0750\*
- forms (Form7s, etc.) (Order Desk) ..... 344-3862 ..... 1-800-387-0750\*
- health care billing cards ..... 344-2937/6/5 ..... 1-800-387-0750\*
- policy information (ask for the analyst on call) re:
  - benefits ..... 344-4330 ..... 1-800-387-0750\*
  - diseases ..... 344-4361 ..... 1-800-387-0750\*
  - revenue ..... 344-4146 ..... 1-800-387-0750\*
- policy manuals, *Policy Report*  
(Policy Publications) 344-4355 ..... 1 800 387-0750\*
- service in French or other languages  
(Multilingual Services) ..... 344-2000 ..... 1-800-387-0750\*
- third-party election forms (Legal Branch) .... 344-2953 ..... 1-800-387-5540

## To reach ..... call 416 .....or, toll free

- Downsview Rehabilitation Centre ..... 244-1761 ..... 1-800-387-7730
- WCB library ..... 344-4052 ..... 1-800 387-0750\*
- WCAT (appeals tribunal) ..... 598-4638
- WCB online : E-mail address: wcbcomm@gov.on.ca, Web site address:http:\\ www.wcb.on.ca
- TTY line for the hearing impaired ..... 1-800-387-0050
- media enquiries (Communications) ..... 344-4182 ..... 1-800-387-0750\*

\*This is a general number which can be reached from anywhere in Canada.  
To reach the extension you want, give the operator the last four digits of the local number provided.



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-P 56

# POLICY REPORT

A publication of the Workers' Compensation Board of Ontario

Volume 9, Number 5 November 1996

Work-related asthma.....1  
Surcharges all but eliminated.....1

## Work-related asthma

New policy & guidelines for determining permanent impairment

**S**hortness of breath. Wheezing. Coughing. Chest tightness. These—with varying severity and persistence depending on the individual—are some of the symptoms of asthma, a respiratory illness common to some 1.2 million Canadians.<sup>1</sup> Asthma is an illness in which there is an episodic narrowing of the airways (bronchial tubes) of the lungs that makes it difficult to breathe. When exposed to triggers such as dust, smoke, fumes, latex, the airways become swollen or inflamed or “twitchy,” excess mucus forms, and the smooth muscle around the airways tightens. It’s hardly surprising then that breathing becomes difficult. Triggers, as is evident from this very short list, can be work- or non-work-related.

Following consultation with the medical community and WCB stakeholders, the WCB recently approved policy and guidelines for determining the degree of a worker’s permanent impairment due to work-related asthma, replacing the informal medical guidelines previously used. This article provides an **overview** of the new policy. For full details, see OPM document 04-03-04.

The new policy outlines procedures for assessing a worker’s respiratory and immunological impairment to be used in conjunction with the process for calculating non-economic loss (NEL) benefits. See the Oct. ’94 issue of *Policy Report* which describes the “generic” NEL process.

The process for calculating a worker’s NEL benefit for asthma is similar to the generic NEL process.

- The worker must have an accident date<sup>2</sup> of January 2, 1990 or later, entitlement to WCB benefits for a work-related injury/disease (in this case work-related asthma), be at maximum medical rehabilitation (MMR), and have indications of a permanent impairment.
- The worker must choose a physician to conduct the NEL assessment from a roster of respiratory physicians provided by the WCB.
- The WCB sends the chosen roster physician a copy of the worker’s medical file including reports of all medical tests.
- The roster physician reviews the worker’s file, assesses the worker, records findings, and describes the worker’s permanent impairment in a narrative report which is sent to the WCB.

## Surcharges all but eliminated

**U**p until 1993, if employers had accident costs higher than the average for their industry the WCB added surcharges to their assessments.

Where the work injury frequency and the accident cost of the employer are consistently higher than that of the average in the industry in which the employer is engaged, the Board, as provided by the regulations, may increase the assessment for that employer by such a percentage thereof as the Board considers just, and may assess and levy the same upon the employer, and may require the employer to establish one or more safety committees at plant level.

103(8)

## Work-related asthma

(continued from p. 1)

- The NEL adjudicator reviews the physician's report and calculates the worker's NEL benefit for the work-related asthma.

The NEL process for asthma differs from the generic NEL process in the use of the American Thoracic Society's "Guidelines for the Evaluation of Impairment/Disability in Patients with Asthma"<sup>3</sup> ("ATS Guidelines"), instead of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (AMA Guides).<sup>4</sup> The "ATS Guidelines" is used because the AMA *Guides* do not provide precise advice on how to determine the degree of permanent impairment due to asthma. So, in an approach supported by legal advice and consultation results, the WCB supplements the AMA *Guides* with the "ATS Guidelines."

## Policy overview

This new policy instructs WCB decision-makers to determine the degree of a worker's permanent impairment due to asthma in terms of (a) respiratory impairment, and/or (b) immunological impairment. Respiratory and immunological impairments are then combined into an assessment of the whole person and a final rating is determined.

## Respiratory impairment

As recommended by the "ATS Guidelines," to assess respiratory impairment, the policy calls for the assessment of

- airflow limitation
- airways hyperresponsiveness
- minimum medications needed to remain stable.

The roster physician examines the worker and reviews the worker's medical reports with regard to each of these components.

### Airflow limitation

Based on information from medical reports, the roster physician scores the volume of air the worker can forcefully expire in one second (FEV<sub>1</sub>) after maximum inspiration. Scores range from 0, if the worker's FEV<sub>1</sub> is greater than the lower limit of normal, to 4, if the worker's FEV<sub>1</sub> is less than 50% of normal.

### Asthma medication

Asthma is treated with two basic types of medication, bronchodilators and anti-inflammatories.

Bronchodilators - sometimes called "relievers," open airways by reversing airways spasm. Examples include, inhaled beta-2 agonists, theophylline tablets and inhaled ipratropium bromide. These medications are used to relieve symptoms after exposure to a trigger substance.

Anti-inflammatories - sometimes called "preventers" or "controllers," help to prevent asthma by reducing inflammation, swelling and mucus in the airways. They are prescribed if bronchodilators are not relieving symptoms effectively. Examples include, corticosteroid inhalers, corticosteroid tablets, sodium cromoglycate and nedocromil.

Both types of medication are most frequently administered through an inhaler, but they may also be prescribed in tablet or liquid form.

### Airways

#### hyperresponsiveness

By definition, a person with asthma has hyperresponsive airways. When exposed to a trigger the airways react or "twitch." Using the information from medical reports the roster physician determines the extent of airways hyperresponsiveness based on either (a) the reversibility of FEV<sub>1</sub> or (b) the degree of airways hyperresponsiveness, as measured by methacholine challenge tests. Scores range from 0 to 4.

### Medication use

To be as precise as possible about reporting medication use, the worker is asked to bring all the asthma medication the worker is using to the NEL medical assessment. The roster physician scores medication use from 0, if no medication is used, to 4, if the worker uses a bronchodilator on demand, as well as a daily high-dose inhaled steroid.

### Rating respiratory impairment

Upon receiving the roster physician's report, the NEL adjudicator totals the scores from the three components—airflow limitation, airways hyperresponsiveness, and medication use—and converts the total to a percentage permanent impairment rating for the respiratory system.



Permanent impairment ratings range from 0%, based on a total ATS score of 0, to 90% based on an ATS score of 11. Uncontrolled asthma, despite maximal treatment, could result in a respiratory impairment rating of 95-100%.

Before making a final determination of the worker's permanent impairment, the NEL adjudicator reviews the roster physician's report for details of any immunological impairment.

## Immunological impairment

While the role of the immune system in the development of asthma is not completely understood, when immunologic stimuli play a role, the worker is described as "sensitized." Sensitization is described as, "the initial exposure of an individual to a specific antigen, resulting in an immune response; subsequent exposure then induces a much stronger response."<sup>5</sup> An antigen is described as, "any [foreign] substance which is capable...of inducing a specific immune response and of reacting with the products of that response, that is with specific antibody or specifically sensitized T-lymphocytes, or both."<sup>6</sup>

Immunologic sensitization is determined by (a) detecting specific IgE antibodies in a skin or blood test, or (b) noting that the worker reacts with asthmatic symptoms to **extremely low** concentrations of a substance.

## Rating immunological impairment

If the roster physician indicates that the worker has a clinically significant sensitization<sup>7</sup> to a workplace substance, the WCB considers the worker to have an immune system impairment of approximately 3% to 5%. Sensitization to a common substance results in a higher rating than sensitization to a substance seldom found.

## Final rating - whole person impairment

To recognize the impairment of the whole person, the NEL adjudicator uses the Combined Values Chart in the *AMA Guides* to combine the total respiratory rating with the immunological rating.

The NEL adjudicator also takes into account any unusual circumstances that may exist and that may affect the worker's permanent impairment. These circumstances could include: barriers to compliance in treatment, limitations to environmental control measures, coexisting diseases, particular sensitivities to exposure to cold which might limit time spent outdoors, or any other impact of asthma on the worker's daily routine. The roster physician should describe any unusual circumstances or factors in the narrative report.

## Aggravation of pre-existing asthma

A worker with a work-related aggravation of pre-existing asthma could have a NEL assessment to determine whether—after reaching MMR—the worker's permanent impairment has increased and, if so, by how much.

If the worker's permanent impairment has increased, the NEL adjudicator deducts the pre-existing percentage impairment from the current impairment.

If the pre-existing percentage impairment is not known, the WCB applies the Second Injury and Enhancement Fund (SIEF) policy for transfer of costs (see 08-01-05).

## Application date

This policy applies to NEL assessments for asthma conducted on or after December 5, 1995. □

## Endnotes:

<sup>1</sup> The Lung Association - Asthma - Facts About Your Lungs

<sup>2</sup> The accident date, in occupational disease claims, is the date of diagnosis of the work-related disease or the date of the first report of medically related symptoms, whichever is the earlier.

<sup>3</sup> American Thoracic Society. Medical Section of the American Lung Association. Guidelines for the Evaluation of Impairment/Disability in Patients with Asthma. *Am. Rev. Respir. Dis.* 147:1056-61, 1993.

<sup>4</sup> American Medical Association. *Guides to the Evaluation of Permanent Impairment* (Third Edition Revised). American Medical Association, Chicago, 1990.

<sup>5</sup> *Dorland's Illustrated Medical Dictionary*. 26th ed. (Toronto: V.B. Saunders Company, 1990), p. 1188.

<sup>6</sup> *Dorland's*, p. 90.

<sup>7</sup> A sensitization is considered to be clinically significant if the worker is sensitized, and, upon exposure to the workplace substance, the worker experiences asthmatic symptoms. The level of exposure need not be excessive.

## Surcharges all but eliminated

(continued from p. 1)

The WCB recently approved a new policy on s.103(8) surcharges. As a result

- the WCB discontinued the s.103(8) program and is not issuing any s.103(8) surcharges for 1993 and later assessment years.
- the WCB is limiting appeals of s.103(8) surcharges to the 1992 issue of the surcharge (the most recent issue, released in early 1994, covers the 1990 - 1992 period). The WCB will consider written appeals, outlining the reasons for the appeal, received on or before December 31, 1996.
- the WCB is continuing to process any appeals that have been received from issues prior to 1992.

The s.103(8) program was suspended for the accident years 1993 and 1994 to allow the 219 new rate groups in the WCB's new classification system to accumulate a three year accident cost and frequency experience. The last bulk issuance of s.103(8) surcharges—for the 1992 assessment year—was issued in early 1994 based on the accident experience under the old rate groups for the years 1990, 1991 and 1992. Given the expansion in NEER\* coverage during that time, only 90 employers met the s.103(8) eligibility criteria in this issue.

The combination of moving all rate groups into NEER or CAD-7\*\* experience rating programs by 1995, and the existing policy of excluding NEER and CAD-7 employers from s.103(8) surcharges, excludes all but an estimated 25 small employers from the s.103(8) surcharges for 1995 and subsequent assessment years.

The WCB considers that experience rating programs (NEER and CAD-7) are a better and fairer way to evaluate recent accident experience. For example, NEER evaluates accident costs on an accident year basis, with the cost estimates progressively refined over a three-year review period. □

\* NEER is an acronym for New Experimental Experience Rating Program. It has as its basic concept the principle of prospective and retrospective rating. For full details see OPM document 08-05-04.

\*\* CAD-7 is an acronym for Council Amendment to Draft 7. It is an experience rating program specifically for the construction industry. For full details see OPM document 08-05-02.

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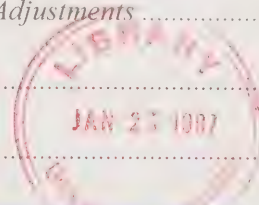
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A publication of the Workers' Compensation Board of Ontario

Volume 9, Number 6 December, 1996

# Cost relief policies revised

Workers' compensation resulted from an 'historic compromise' which altered the relationship between employers and workers faced with a work-related injury. Workers gave up the right to sue their employer, and in exchange they were relieved of the burden of proving employer negligence in order to receive compensation for their losses. The *Act* provides a cushion to employers against the potentially crippling costs of law suits, and makes compensation payable to workers regardless of fault.

Under the *Act*, when a worker in an industry listed in Schedule 1 (see box, p.2) has a work-related injury, the WCB pays the costs of the claim out of the accident fund—a pool of assessment revenue from contributing employers. Employers' assessments are set so that claims' costs are shared among all employers in the same industry, while responding to good and bad records of individual employers through a mechanism called 'experience rating'.

But what happens when a work-related accident is caused by the negligence of a third party—someone other than the worker or the employer? Do the worker and employer enjoy the protection they gained from the historic compromise? ... and who pays the bill?

The OPM covers this topic in three policies: *Transfer of Costs*, 08-01-10; *Removal of Costs*, 08-01-11; and *Third Party Motor Vehicle Accident Claim Costs*, 08-05-08. These three policies were revised in May 1996.

### Scenario A

Consider Sam, a delivery man for Computer Systems Stores (CSS), a Schedule 1 employer. He is on the road, and in and out of other employers' premises all day. Consequently, he is frequently exposed to dangers outside the purview of his employer. One day Sam slips on a wet floor while on delivery at Silverman's Hardware. Silverman's is a Schedule 1 employer too.

The costs arising from this accident would be handled under the *Transfer of Costs* policy. It states that if a work-related accident appears to be due to the negligence of a third party who is a Schedule 1 worker or employer, like Silverman's, the WCB pays the claim and initially charges the costs to the injured worker's employer, CSS in our example.

If any compensation benefits are paid, or if health care benefits exceed \$500, the WCB investigates the circumstances of the accident to determine if the third party was negligent, and if so to what degree.

The adjuster assigns a percentage to any degree of negligence discovered,

and transfers this percentage of the claim costs to the third party.

Injured workers do not have the right to sue the third party in these cases since the *Act* extends protection against legal action to a third party who is a Schedule 1 worker or employer.

### Scenario B

Imagine Sam again, this time he is bitten by a dog while on delivery at a private residence, not covered under Schedule 1.

The costs arising from this accident would be handled under the *Removal of Costs* policy. It states that if a work-related accident appears to be due to

the negligence of a third party who is not covered by Schedule 1, such as the homeowner in our example, the worker may choose to sue the third-party and not claim WCB benefits; or claim WCB benefits, and forfeit the right to sue.

If the worker sues the third party and receives a court award or a WCB-approved settlement\* amounting to less money than the worker would have received from the WCB, the worker may claim the difference. This is charged to the employer's account.

On the other hand, if the worker claims benefits, the WCB may take legal action against the third party on the worker's behalf, depending on several factors including estimated costs vs. gains. Any amount recovered through legal action is credited to the employer's account to offset the costs of the claim. If the settlement exceeds what the WCB pays out in benefits and legal costs, the remainder, which is called a surplus, is turned over to the worker.

### Scenario C

*This time Sam is in between deliveries when he gets in a car accident involving another vehicle.*

How the WCB handles the claims costs in this case depends on whether or not the other driver is covered under Schedule 1. The policy *Motor Vehicle Accident (MVA) Claim Costs* explains this further.

If a work-related MVA appears to be due to the negligence of a third party, the WCB pays the claim and initially charges the costs to the worker's employer. The WCB then investigates the accident to determine if the third party was negligent (even though Ontario's auto insurance scheme mostly does away with 'fault'). If so, and if the third party was not covered under Schedule 1, the adjuster sets the degree of negligence as a percentage, and removes that percentage of the claim costs from the employer's experience rating record.

If, however, the third party is someone covered under Schedule 1, such as a long haul truck driver, rather than simply removing these costs, the WCB transfers them to the account of the "negligent" employer. Again, the WCB proceeds this way even though the no-fault auto insurance scheme mostly abolishes the notion of 'fault'.

Finally, if the worker is able to sue the third party, the procedure described in the *Removal of Costs* policy applies. The worker must choose between suing the third party and claiming WCB benefits.

Workers who sue, and receive a court award or a WCB-approved settlement that is less than what they would have received from the WCB, are entitled to the difference. This amount is initially charged to the employer's account. Workers who claim WCB benefits receive them, and again the costs are initially charged to the employer. In either case, an adjuster determines if there is negligence, and costs are removed from the employer's account accordingly.

If the WCB pursues legal action on behalf of the worker, and receives a court award or settlement greater than the amount removed from the employer's account, the WCB removes the difference from the employer's account, up to the full cost of the claim. Any amount exceeding what has been paid to the worker in benefits, is turned over to the worker as a surplus. The WCB then withholds further benefits until they exceed the surplus. Future benefits not covered by the court award or settlement are charged to the employer's account.

For more information see the OPM documents cited above, or call Revenue Policy at (416) 344-4150, or 1-800-387-0750.

\* For a worker to claim benefits above the amount of an out-of-court settlement, the WCB must pre-approve the amount of the settlement.



## New time limits on retroactive adjustments

Ontario's workers' compensation system is funded by participating employers. When a company applies for coverage, the WCB classifies it according to its business activity, and tells the company what rate to pay on each \$100 of assessable\* payroll. This rate reflects the risk of accidents in that business activity. The amount a company owes the WCB is called its assessment.

If an employer has paid an incorrect assessment, the WCB may adjust the employer's account retroactively, in keeping with a new policy entitled *Retroactive Adjustments*. The new policy focuses on early identification of incorrect activity in employer accounts. It applies to incorrect assessments the WCB becomes aware of on or after January 1, 1997.

Both the WCB and employers play a part in determining the amount of an assessment. The process follows several steps, as outlined below. If the WCB or an employer discovers that an error was made at any step, the WCB makes a retroactive credit or debit adjustment.

To determine the amount of assessments, the WCB must

- classify employers
- determine assessment rate(s), and
- charge interest and non-compliance penalties when appropriate.

And employers must

- accurately report their assessable earnings—which may fall under more than one rate, and
- calculate the amount of their assessment.

### The general rule

The general rule limits the WCB to applying credits or debits to only the last two assessment years which have been reconciled. The policy states:

In general, the WCB only adjusts accounts in the two assessment years—for which the reconciliation date has passed—immediately prior to the year in which the need for adjustment was discovered.

Three examples illustrate this rule.

### Example A: An incorrect classification in two years or more.

*Jones Contracting was incorrectly classified for 7 years. When they discovered this and informed the WCB in June of 1997, the WCB made a retroactive adjustment to their account through 1995 and 1996, the two assessment years immediately prior to discovery of the error.*

### Example B: Over-reporting in less than two years.

*Morrison Facilitation & Mediation Consultants reported excess payroll in 1996. The WCB discovered this in September 1997 and adjusted the account for 1996, since the over-reporting only appeared on the 1996 assessment.*

In examples A and B the problem was discovered after reconciliation—when businesses compare what they've paid to the WCB over the year, to what they should have paid based on their year-end earnings. The reconciliation due date is generally in the spring of the following year. From 1997 onwards, it will be on March 31. If a problem is discovered after December 31 (the end of the assessment year), the WCB may adjust the account in the two years prior to the year yet to be reconciled. See example C.

### Example C: An incorrect assessment discovered prior to the reconciliation date for the assessment year just past.

*The WCB audited the Barney Trust Co. in February 1997 and discovered an error in their assessment calculation dating back five years. Since the reconciliation due date (March 31) had not yet passed for the 1996 assessment year, the WCB adjusted the Barney account for 1994 and 1995, expecting the same error would not be made again in the 1996 reconciliation.*

*If the error had only dated back one year, the WCB would have made the adjustment for 1995 alone.*

### Exceptions to the general rule

The two-year restriction applies to all credit adjustments, but it does not apply to debit adjustments resulting from an employer

- failing to fully disclose information to the WCB,
- committing a fraudulent act or an offence under the *Act*, or
- filing a provisional assessment which is not followed by a year-end Reconciliation Statement.

If an employer fails to fully disclose information, the WCB may make a debit adjustment to the account in **up to five years prior** to the year in which the WCB became aware of the incorrect assessment. Failing to fully disclose information includes

- failing to register
- delaying disclosure of, or withholding information relevant to an assessment, and
- providing incomplete or inaccurate information to the WCB.

(cont'd p 6)

\*For 1996, the maximum assessable earnings for one worker is \$55,600

## Changes to registration policy & process

In September 1996 the WCB revised the policy on employer registration, introducing three significant changes:

- Schedule 2\* employers are now required to register with the WCB
- employers are to register within 10 days of their first worker starting to work, and
- employers may hold multiple accounts—recognising that some employers may find it more convenient to handle claims and assessments on a lower level, e.g., at the branch, factory, office, or outlet.

### Who must register?

All employers in an industry listed in Schedule 1 or 2 of the *Act* must register. Employers in industries not listed in the *Act* are not obliged to register, but if they do apply for coverage, they too must follow the standard registration process. This is also true for independent operators and others applying for personal coverage. (See 08-02-03.)

### The 10-day rule

With the passing of *Bill 15* in 1995, the government made it necessary for those employers who are required to register, to do so within 10 days of their first worker starting to work. Employers who fail to register on time are subject to penalty. (See 08-08-03.)

To meet the 10 day rule, employers may contact the WCB by telephone, fax, letter, or in person.

Schedule 1 employers must provide:

- the legal employer name and mailing address, to identify responsibility for liabilities, i.e., the name of the company or business appearing on paycheques and T4 slips

- a description of the business activities
- the date the first worker started, and
- an estimate of assessable earnings.

Schedule 2 employers must provide:

- the legal employer name (same as above) and mailing address, and
  - the date the first worker started.
- Also, they must indicate:
- whether the employer is federally or provincially regulated, and
  - whether the employer is privately or publicly incorporated.

Once this first contact is made, the WCB sends the employer a New Registration Kit. To complete the registration process the employer, or an authorized officer, must complete, sign, and return the Employer Registration Form found in that kit.

### Accounts, multiple accounts, & financial responsibility

The WCB assigns each new employer an account. The account is set up in the 'legal employer name' as indicated on the Employer Registration Form. All financial transactions between the employer and the WCB are recorded in this account. Employers report their assessments and claims by account, and pay their assessments by account.

Most employers have only one account, but with the new policy Schedule 1 employers may have multiple accounts configured however best suits them. Each account must have an actual work location, with its own mailing address, telephone number, and dedicated workforce, and

can represent any one, or any combination, of the following:

- head office
- sales office
- warehouse
- division
- factory
- store
- any operating facility or work location.

For employers with multiple accounts, all of their accounts are linked at the organizational level, and financial responsibility for them lies with the legal employer as registered.

### Exception

Employers in the construction industry are allowed only one account per rate group.

### Signing authority

If employers want to change their account data, or how they report their assessments, the request must be made by the legal employer or an officer authorized to represent the legal employer. Consequently, certain forms like the Employer Registration Form, and the 'Request to Change' portion of the Assessment Frequency notice, can only be signed by the legal employer or an authorized officer.

For more information on employer registration, see the OPM or call Revenue Policy at (416) 344-4150 or 1-800-387-0750.

\* Schedules 1 & 2 are found in Regulation 1102, at the end of the *Act*. The box on p.2 provides description of Schedule 1 and 2. To find out if your business must register, call Employer Association at 1-800-344-1038 or 1-800-387-8638

## New collections policies

The WCB recently reviewed its policies on collecting overdue employer assessments. The aim was to make these policies simpler, more reflective of how business is carried out, and to give WCB staff more flexibility to resolve accounts appropriately. The three revised policies are: *Suspension of Collection Activities*, 08-07-01; *Collections Based on Financial Hardship*, 08-07-02; and, *Writs for Seizure and Sale of Property*, 08-07-04.

### Suspension of collection activities

This policy outlines when a WCB collector might 'suspend', i.e., temporarily stop, collection. It also explains how employers provide 'security' to the WCB, in order to have collection suspended. Security here means something given or done to guarantee payment of a debt.

When employers appeal an assessment, the WCB expects them to continue to pay the assessment, any previously owing amounts, and accruing interest while the appeal is underway. The WCB will suspend collection of the amount in dispute if the employer negotiates a letter of credit with a bank.

A letter of credit guarantees the WCB that the money in dispute will be paid immediately, should the appeal decision require payment. At the same time, it relieves employers of their obligation to pay the disputed amount until the appeal is settled.

Letters of credit are only valid through one level of appeal, and they must be approved by the WCB before collection is suspended. An employer who pursues an appeal at more than one level, requires a letter of credit at each one.

### Collections based on financial hardship

This policy describes how the WCB determines whether an employer is experiencing financial hardship, and how the WCB uses phased payment plans to structure payments for those employers who are. The policy also outlines the steps the WCB takes if an employer defaults on a phased payment plan.

Employers must pay overdue amounts to the WCB immediately, unless they can provide evidence of financial hardship. That evidence may include cash flow projections, credit reports, financial statements, etc. In deciding whether to offer relief, the WCB considers the evidence provided along with:

- the employer's payment history and compliance record
- whether the employer is co-operative and willing to pay the debt, and
- the length of time over which the employer is to pay it.

The WCB may demand immediate payment, offer a phased payment plan, partial forgiveness, or suggest another course of action.

The WCB uses phased payment plans to help employers pay their debts as quickly as possible, without causing undue hardship. The WCB negotiates the contents of the plan with the employer, and reviews it periodically. If an employer's situation improves or worsens significantly, the plan may be re-negotiated.

When an employer on a payment plan requests a Clearance Certificate\*, the WCB may re-negotiate the payment plan, requiring additional or stepped-

up payment of the debt as a condition of releasing the certificate.

### Security

The WCB may secure a phased payment plan by issuing a Certificate with the Court for the overdue balance and filing a Writ of Seizure and Sale (see below), or through other methods acceptable to the WCB (see 08-07-04). If an employer defaults on a plan, the WCB may require full payment immediately, enforce the Writ or other security, and/or hold the employer responsible for the full cost of all claims occurring on or after the first day payment was overdue.

### Late payment charges

- The WCB may waive or suspend late payment charges relating to an employer's debt if:
- the employer demonstrates the failure to pay the debt resulted from financial hardship or circumstances beyond its control
- payment of such charges would, itself, create undue hardship for the employer, or would result in an unreasonable arrangement considering the employer's current and projected financial circumstances, or
- an error or delay attributable to the WCB contributed to the employer's lateness.

### Writs of Seizure and Sale of Property (Writs)

This policy outlines when the WCB obtains a judgement—which allows the WCB to assert its right to an employer's assets—and when the WCB enforces a judgement.

\* The WCB issues Clearance Certificates to contractors whose accounts are in good standing. The certificate confirms that the principal will not be liable for unpaid assessments of the contractor during a specified time period.

The WCB may obtain a judgement for an overdue amount when an employer defaults in the payment of an assessment. By law, the WCB automatically obtains a judgement from the Court, without having a trial on the issue.

Immediately upon obtaining a judgement, the WCB files a Writ to protect its interests. The Writ is a lien upon the property of the employer. It remains in effect during the term of any payment proposal.

Before taking further enforcement measures, the WCB considers how much the employer owes, how late the payment is, and the employer's compliance history.

Generally, the WCB enforces a judgement when:

- an employer refuses to make payment the WCB considers the employer capable of making
- an employer is unresponsive or uncooperative when the WCB has attempted to make contact
- an employer is transferring assets, and the WCB suspects it is an attempt to evade collection
- the employer defaults on a phased payment plan, or
- the WCB has not been able to negotiate a phased payment plan with the employer within 60 days of the account becoming overdue.

Enforcing a judgement may take the form of filing and levying a Writ, or other proceedings. The WCB notifies employers of its intention to file a Writ against them, and may temporarily lift Writs or other enforcement proceedings to allow an employer to complete a specific transaction, provided the employer makes an arrangement to secure the debt that satisfies the WCB.

Once the employer pays the amount due, the WCB withdraws the Writ, or ceases other enforcement proceedings.

For more information on the WCB's collections procedures, contact Employer Collections, Hamilton Regional Office, at (905) 523-1800, or 1-800-263-8488.

## Consultation invited

The Occupational Disease Panel recently submitted the following report to the WCB:

*Report to the WCB on  
Dupuytren's Contracture  
and Hand Injury*

Copies are available from:

Occupational Disease Panel  
69 Yonge Street, Suite 1004  
Toronto, ON M5E 1K3  
Tel: (416) 327-4156

If you would like to provide the WCB with comments, briefs, or submissions concerning the findings and recommendations, send them to:

Ms. Linda Angove  
Secretary to the Board  
Workers' Compensation Board  
200 Front Street West, 17th floor  
Toronto, ON M5V 3J1

The submission deadline is  
February 28, 1997.

## Retroactive adjustments (cont'd from p.3)

Where an employer commits fraud, or does not reconcile an account after paying a provisional assessment, the WCB may make corrective retroactive debit adjustments to the employer's account in **any prior year**.

For more information see 08-01-09 *Retroactive Adjustments*, or call Revenue Policy at 1-800-387-0750 or (416) 344-4150.

# POLICY REPORT



Workers'  
Compensation  
Board

Commission  
des accidents  
du travail

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In this publication, "the Act" refers to the Workers' Compensation Act unless otherwise stated. "OPM" refers to the WCB's *Operational Policy* manual.

The WCB also publishes the *Employer Classification* manual and a bilingual lexicon.

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Volume 10, Number 1 February 1997

# Clothing allowance policy revised

Section 50(3) of the *Act* provides that when a worker's permanent impairment requires treatment involving the use of an **orthotic** or a **prosthetic** device, the worker may be entitled to an allowance for clothing worn or damaged by the device.

Clothing allowances are meant to compensate workers for the **actual** damage caused from wearing an orthotic or prosthetic device.

Recent clinical studies indicate that most modern orthotic and prosthetic devices cause very little damage to clothing. There is also evidence that for maximum medical benefit, most orthotic devices should be worn for a short period of time. Wearing an orthotic device continuously over a prolonged period of time may cause some injuries to worsen.

### Orthotic device -

an appliance (such as a back or knee brace) that enhances function and ability.

### Prosthetic device -

an appliance (such as an artificial hand or leg) that replaces a missing part of the body.

A review of the WCB's 1992 clothing allowance policy identified several problems:

- The policy required decision-makers to pay the same amount of clothing allowance even though different devices cause substantially different amounts of actual damage to clothing.
- The intent of the *Act* is to provide a clothing allowance to compensate workers for actual clothing damage. This was not always the result since it was possible to pay clothing allowance even though there may have been little or no damage to clothing.
- The policy did not encourage decision-makers, when considering a renewal application, to ensure that the orthotic or prosthetic device continued to meet a legitimate medical rehabilitation need.

Consequently, in November 1996, the WCB revised its policy to ensure that there is a more reasonable connection between the amount of the clothing allowance paid and known patterns of clothing damage.

The revised policy also directs decision-makers to undertake enhanced medical monitoring when clothing allowance applications are

reviewed to determine whether there is an ongoing need for the device or whether a different medical rehabilitation approach would be more appropriate for the worker.

### Other highlights of the policy

- Workers are entitled to one clothing allowance when they must wear an upper body device, and/or one clothing allowance when they must wear a lower body device.
- Workers are required to wear a device for one year after receiving a non-economic loss (NEL) or permanent disability (PD) benefit before applying for a clothing allowance.
- Workers must submit an application to renew a clothing allowance annually on the anniversary date of the NEL or PD award (the clothing allowance "due date").
- The WCB may exempt severely injured workers from having to submit an annual application for renewal, if the worker's condition is unlikely to change.
- The WCB may require a worker to submit a report from an orthopaedic specialist giving objective medical reasons why the device is necessary

Continued on page 4.

# Health care outside Ontario

Providing injured workers with top quality health care, and managing it in an efficient and cost-effective manner, are two primary concerns of the Ontario WCB. Managing out-of-province health care adds an extra element of difficulty. As a result, the WCB recently fine-tuned its out-of-province health care policy.

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*For the purpose of this policy, **emergency health care** is the initial treatment that is required following an accident or a recurrence of an injury or occupational disease.*

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***Elective health care** is treatment that can be scheduled in advance.*

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Normally, workers are expected to receive health care in Ontario, but there can be situations when emergency or elective health care outside of the province is medically appropriate. Over the years, the Ontario WCB has covered the cost of health care received by injured workers in at least 57 countries, and the 11 other provincial and territorial jurisdictions in Canada.

When handling requests for health care from locations around the world, the WCB must exercise control over, and ensure the consistency of, the treatment rendered and the fees charged. This ensures that workers are getting the care that best suits their needs, at a reasonable cost.

## Pre-approval

If workers require emergency treatment outside the province, they

are not expected to check with the WCB for pre-approval,\* but when it comes to elective out-of-province health care, the treatment and its location must be pre-approved.

## Ontario residents

Ontario workers may be entitled to necessary elective health care outside of Ontario

- when the required health care is not available in Ontario. When making this decision, the WCB considers whether a particular treatment provided in Ontario is equivalent to that offered outside of the province. The WCB is guided by the opinion of its medical advisors in these cases; or
- when the out-of-province treatment is medically appropriate. This applies when the worker's health could be put at risk by travelling a longer distance or waiting a longer period for treatment in Ontario. Risk can be measured by factors such as the possibility of significant deterioration, increased chance of permanent impairment, or the potential that a stabilized condition may worsen; or
- when the WCB has adopted or negotiated a service agreement with an out-of-province agency (e.g., WCB adoption of Ministry of Health Preferred Provider Network for magnetic resonance imaging services in the United States), and there is evidence that there will be reduced claim costs due to lower travel expenses and/or an earlier return to work.

## Non-resident workers

Out-of-province health care can also be required in cases involving non-resident workers. These are workers who are covered by the Ontario Act but who were living outside the province at the time of the accident, or who moved out of Ontario after an accident.

Regardless of where their initial emergency treatment is provided, non-residents who maintain an employment connection to Ontario (e.g., they are employed by an Ontario company) can choose to receive elective treatment in Ontario or in the community in which they reside. However, if there is no longer an employment connection with Ontario (e.g., the worker retires or takes a new job outside the province) workers are expected to receive elective treatment in their own community, and the WCB does not continue to pay for treatment in Ontario, unless otherwise authorized.

The same criteria that apply to Ontario residents requesting out-of-province treatment apply to non-resident workers requesting treatment outside of their community. It may be approved when:

- the required health care is not available in their community; or
- the out-of-province treatment is medically appropriate; or
- the WCB has a service agreement with an out-of-province agency.



# 1997 facts and figures

Each year, WCB benefits are indexed to help keep pace with inflation. On the left, you'll find the applicable section of the *Act* and the legislated dollar amount. On the right, you'll find the latest indexed figures.

Section	Description	1996 \$ - Amount	1997 \$ - Amount
35(1)(a)	Lump sum to surviving spouse: Base amount = \$40,000	55,389.38	55,555.55
	Age factor: Plus/minus \$1,000 for each year spouse is under/over age 40	1,384.73	1,388.88
	Maximum lump sum = \$60,000	83,084.05	83,333.30
	Minimum lump sum = \$20,000	27,694.68	27,777.76
35(7)	Aggregate lump sum payment for children when there is no surviving spouse = \$40,000	55,389.38	55,555.55
35(9)	Minimum burial or cremation expenses = \$1,500	2,077.09	2,083.32
35(17)	When more than one person is entitled to receive periodic and lump sum payments as a spouse, the total periodic payment may not exceed		
	• 90% of worker's net average earnings (NAE) at the time of injury, and		
	• the total lump sum payment is limited to \$60,000	83,084.05	83,333.30
38	Maximum earnings ceiling: 175% of the average industrial wage for Ontario for the year in which the accident takes place	55,600.00	56,100.00
39(1)	The minimum temporary total disability benefit to a worker is		
	• \$10,500/year when the NAE are equal to or more than \$10,500 or	15,266.71	15,312.51
	• the actual NAE if earnings are less than \$10,500/year		
39(3)	The minimum compensation amount used for spouse and children under s.35(4),(5),(6) = \$11,025	15,266.71	15,312.51
42	NEL (non-economic loss) benefit: Base amount = \$45,000	51,381.23	51,535.37
	Age factor: Plus/minus \$1,000 for each year worker is under/over age 45, to a maximum of \$20,000	1,142.20	1,145.63
		22,836.01	22,904.52
	The benefit is paid as a lump sum if it is \$10,000 or less	11,417.82	11,452.07
44(7)	Retirement pension: Pension is paid as a lump sum if it yields less than \$1,000/year	1,141.80	1,145.23
50(3)	Maximum clothing allowance:		
	• upper limb prosthesis = \$184	254.79	255.55
	• lower limb prosthesis/back brace/leg brace = \$368	509.59	511.12
147(14)	Additional monthly payment of up to \$200 for workers in receipt of permanent partial disability benefits	201.60	202.20

Note: For 1997, the indexing amount using the Consumer Price Index (CPI) is 1.7% and the Friedland formula amount is 0.3%. For an explanation of how these indexing factors work, see Policy Report Volume 8 Number 1.

# Faits et chiffres pour 1997

Chaque année, la CAT indexe ses indemnités en fonction des variations du taux d'inflation. Dans les deux premières colonnes, vous trouverez respectivement le numéro de l'article de la *Loi* ainsi qu'une description des indemnités et les montants prévus par la *Loi*. Les deux colonnes de droite indiquent les montants indexés pour 1996 et 1997.

Articles de la Loi	Description et montants prévus par la Loi	Montants pour 1996	Montants pour 1997
35 (1) a)	Paiement forfaitaire au conjoint survivant : Montant de base = 40 000,00 \$ Facteur d'âge : majoration/diminution de 1 000,00 \$ pour conjoint de moins/de plus de 40 ans, pour chaque année entre son âge et l'âge de 40 ans. Maximum = 60 000,00 \$ Minimum = 20 000,00 \$	55 389,38 \$  1 384,73 \$ 83 084,05 \$ 27 694,68 \$	55 555,55 \$  1 388,88 \$ 83 333,30 \$ 27 777,76 \$
35 (7)	Paiement forfaitaire total de 40 000,00 \$ à l'enfant ou aux enfants (aucun conjoint survivant).	55 389,38 \$	55 555,55 \$
35 (9)	Frais d'inhumation ou d'incinération : minimum = 1 500,00 \$	2 077,09 \$	2 083,32 \$
35 (17)	Indemnités versées à plus d'une personne, à titre de conjoint : • Total des versements périodiques : jusqu'à un maximum de 90 % des gains moyens nets du travailleur, au moment de la lésion. • Montant forfaitaire : maximum = 60 000,00 \$.	83 084,05 \$	83 333,30 \$
38	Montant maximal des gains moyens : 175 % du salaire moyen prévalant dans l'industrie en Ontario durant l'année où l'accident est survenu.	55 600,00 \$	56 100,00 \$
39 (1)	L'indemnité minimale payable en cas d'invalidité totale temporaire correspond : • à 10 500,00 \$ par année si les gains moyens nets au moment de l'accident sont de 10 500,00 \$ ou plus; • au montant des gains moyens nets au moment de l'accident si ceux-ci sont inférieurs à 10 500,00 \$ par année.	15 266,71 \$	15 312,51 \$
39 (3)	L'indemnité minimale à laquelle ont droit les enfants à charge, en vertu des par. 35 (4), (5), (6), est de 11 025,00 \$ par année.	15 266,71 \$	15 312,51 \$
42	Indemnité pour perte non économique (PNÉ) : Montant de base = 45 000,00 \$ Facteur d'âge : plus/moins 1 000,00 \$ pour chaque année que le travailleur a de moins/de plus que 45 ans; maximum = 20 000,00 \$  Seuil de 10 000,00 \$ servant à déterminer le mode de paiement.	51 381,23 \$  1 142,20 \$ 22 836,01 \$  11 417,82 \$	51 535,37 \$  1 145,63 \$ 22 904,52 \$  11 452,07 \$
44 (7)	Versements de pension de retraite : Seuil de 1 000,00 \$ déterminant si la pension est versée sous forme de paiement forfaitaire.	1 141,80 \$	1 145,23 \$
50 (3)	Allocation vestimentaire : Montant maximal : • prothèse à un membre supérieur = 184,00 \$ • prothèse à un membre inférieur, corset ou attelle à la jambe = 368,00 \$	254,79 \$  509,59 \$	255,55 \$  511,12 \$
147 (14)	Montant mensuel additionnel pouvant aller jusqu'à 200,00 \$ pour les travailleurs qui reçoivent une indemnité d'invalidité partielle permanente.	201,60 \$	202,20 \$

Remarque : Pour 1997, les montants indexés selon l'IPC sont multipliés par 1,7 % et ceux indexés selon le facteur Friedland par 0,3 %. Pour obtenir des renseignements sur l'application des facteurs d'indexation, se reporter au *Bulletin des politiques*, vol. 8, n° 1.



## Agreements with other jurisdictions

Inter-provincial health care rates have been established between the provinces for services provided to people who have coverage in one province but are receiving treatment in another. Also, the Ontario WCB has negotiated inter-jurisdictional agreements with most other Canadian WCBs,\*\* as well as reciprocal agreements with Italy, Greece, and Portugal.

## No agreement in place

If there is no applicable inter-provincial, inter-jurisdictional, or reciprocal agreement, the WCB pays up to what would be properly and reasonably charged to workers, if the workers were being billed directly and paying the fees themselves in the community where the care is provided.

For more information, see OPM document 06-02-08, *Health Care Outside Ontario*.

\* Those who receive emergency health care outside of Ontario are expected to return for care at an Ontario facility, or with an Ontario health care professional, as soon as possible.

\*\* No Inter-provincial agreement has been signed by Quebec. Quebec health care providers treating Ontario residents are paid based on Ontario WCB treatment rates.

This chart summarizes payment rates for approved health care outside of Ontario.

Worker lives in...	Approved treatment received in...	WCB payment based on...
Ontario	Another province	Inter-provincial rates or rates reasonably charged in that community (guided by provincial workers' compensation or Ministry of Health rates)
	Quebec	Ontario WCB rates
	Another country	Reciprocal agreement rates. If no agreement, rates reasonably charged in that community (guided by local workers' compensation rates, if any)
Another province	Worker's home province	Rates reasonably charged in that community (guided by provincial workers' compensation or Ministry of Health rates)
	Quebec	Quebec Ministry of Health rates, or if none, CSST rates ( <i>Commission de la Sante et de la Securite du Travail</i> )
	Province other than worker's home province	Inter-provincial rates or, if none, rates reasonably charged in that community (guided by provincial workers' compensation or Ministry of Health rates)
	Another country	Reciprocal agreement rates. If no agreement, rates reasonably charged in that community (guided by local workers' compensation or Ministry of Health rates, if any)
Another Country	Canada	Rates reasonably charged in that community (guided by provincial workers' compensation or Ministry of Health rates)
	Outside Canada	Reciprocal agreement rates. If no agreement, rates reasonably charged in that community (guided by local workers' compensation rates or Ministry of Health rates, if any)

Note: If the WCB approves treatment in Ontario, but the worker chooses to obtain the treatment outside the province, the worker is responsible for any costs above the WCB fee schedule.

## Clothing allowance *(cont'd)*

- The wearing/using of wrist gauntlets or crutches may entitle a worker to a clothing allowance.
- Soft cervical collars and prostheses or orthoses for amputations below the wrist or ankle are not eligible for a clothing allowance.

This policy came into effect on November 1, 1996. It applies to all clothing allowance applications with a due date (i.e., a NEL/PD anniversary date) on or after November 1, 1996.

For more information on the clothing allowance policy, see OPM document 06-03-04.

## Schedule of Benefits

**Using the following devices may qualify a worker for a benefit of up to \$368 (indexed to \$511.12 in 1997):**

- back brace - Harris-type, rigid frame
- custom-made knee brace
- permanent leg brace
- manual wheelchair
- leg prosthesis

**Use of the following devices may qualify a worker for a benefit of up to \$184 (indexed to \$255.55 in 1997):**

- arm prosthesis
- cervical brace
- forearm-supported crutches
- under-arm crutches
- off-the-shelf knee brace such as the "Generation 2"
- back support or corset (canvas belt/corset with steel stays to support back)
- arm brace
- wrist gauntlet
- power wheelchair

## The 1997 *Policy Report* Index is now available.

To request a copy, write to Policy Publications at the address on this page, or call  
(416) 344-4355 or  
1-800-387-0750.

# POLICY REPORT



Workers'  
Compensation  
Board

Commission  
des accidents  
du travail

Subscription to *Policy Report* is free.

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If there is any conflict between information in this publication and the *Workers' Compensation Act* or WCB-approved policy documents, the *Act* or the approved policy governs.

In this publication, the "Act" refers to the *Workers' Compensation Act* unless otherwise stated, and "OPM," refers to the WCB's *Operational Policy* manual.

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# POLICY REPORT

A publication of the Workers' Compensation Board of Ontario

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Volume 10, Number 2 July 1997

## Policy Report enters 10th year

If you look at the top right corner of this page, you'll see that we're publishing Volume 10 of *Policy Report* this year. Yes, we in Policy Publications are in our tenth year of bringing you plain-language articles about new workers' compensation legislation, new or revised policies, and special editions with pull-out charts on topics such as the adjudicative process and vocational rehabilitation.

We've also been publishing the *Operational Policy* manual since 1989, the *Employer Classification* manual since 1994, and we look after the sale and distribution of the *WCB Bilingual Lexicon*.

One of the most important reasons we're here is to promote better understanding of WCB policy internally and externally, and from the feed-back we've received from you over the years, it's working! Just to be sure, we've included a satisfaction survey in this issue, which we hope you'll take a minute to complete and return to us.

### The newsletter

*Policy Report* is not fancy. We take the Dragnet approach to reporting information ("Just the facts, ma'am.") We don't use a lot of photos, shiny paper, or snazzy colours. We just try to take legislative and policy information, which we all know can be a bit complicated, and break it down so that it's easy to read and understand, and useful to anyone with an interest in workers' compensation issues. And it's free to subscribers.

*Policy Report* has gone through some changes over the years. When we published the first issue back in 1988 we had a circulation of about 1,200. Now, we have more than 12,000 subscribers all over North America, and as far away as Chile, West-Germany, Zambia, and Puerto Rico. In accordance with the *French Language Services Act*, we began publishing *Policy Report* in both official languages starting with Vol. 2 No. 4 in September 1989. In a cost- and tree-saving effort, we started printing the English and French editions separately last year.

We decided to spruce up the look last year with a new banner and fresh design that's been well received, and we'll continue to look for ways to improve. Your comments and suggestions by phone, fax, or letter are always welcome.

### The manuals

The backbone of Policy Publications' work is the *Operational Policy* manual (OPM). With over 300 policy documents, it is the definitive source of operational policies and guidelines for WCB decision-makers and clients. You can purchase a copy of the OPM, or our other manuals, by calling the number on page 6 of *Policy Report*.

Every employer with WCB coverage is classified by the WCB. The *Employer Classification* manual (ECM) is a comprehensive guide to the WCB's classification scheme. It provides both an overview of the scheme's organization, and a detailed description of each of its 830-plus categories.

continued on page 6

# Legislative change

**H**er Majesty, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows.... This is the introductory phrase to bills which, if passed by the Legislative Assembly, become law. Bill 107, for example, which in 1914 created the *Workmen's Compensation Act* and the Workmen's Compensation Board (WCB), began in much the same way. The WCB was created by legislation, its policies are derived from legislation, and legislative change is the engine that drives it forward.

One way in which the WCB has communicated details of legislative/policy change during the past decade, is through *Policy Report*. This article presents highlights of legislative changes to the *Act* from '84 to '95, a period that corresponds roughly with the existence of *Policy Report*. It is no exaggeration to say that the pace and complexity of legislative change over these 11 years have been unparalleled in the WCB's history. While this may be a reflection of the increasing complexity of Canadian society, it has nonetheless created a challenging environment within which the WCB must operate.

For each bill, we list the year of passage and some of the legislative highlights. Where *Policy Report* has covered the legislative/policy change, cross references to the issue are indicated.

Because Bill 99 has not been through the legislative approval process, it is not included here. However, it is discussed in a companion article on page 5, and future issues will report on it in detail.

## Bill 101 - 1984

Based in large part on a report by Professor Paul Weiler, entitled *Reshaping Workers' Compensation for Ontario* (1980), Bill 101 made the most sweeping changes to the *Act* since 1914.

### Benefits/coverage

- compensation set at 90% of a worker's pre-injury net earnings (previously 75% of pre-injury gross earnings)
- a dual benefit system for survivors (Vol. 2 No. 1)
  - a lump sum payment, and
  - a periodic earnings-related benefit payment
- domestic workers covered under the *Act*
- supplement provisions expanded
- employers pay full wages for day of accident
- compensation payable from day after date of accident

### Board of directors

- a multi-partite board of directors (previously a corporate board composed of Commissioners) (Vol. 1 No.'s 2 & 4, Vol. 3 No. 5)

### External bodies

- Worker's Compensation Appeals Tribunal (WCAT)
- Industrial Disease Standards Panel (Vol. 6 No. 4, Vol. 7 No. 3)
- Office of the Employer Advisor
- Office of the Worker Advisor

## Bill 81 - 1985

This bill introduced the annual indexation of benefits. Before 1985, the Legislature adjusted benefits periodically as it considered appropriate (see page 6).

### Indexing (Vol. 5 No. 4, Vol. 8 No. 2)

- indexing factor based on the Consumer Price Index annually adjusts all dollar amounts in the *Act*, and average earnings, starting in January 1987

## Bill 162 - 1989

### Benefits/coverage

- dual benefit system for workers with permanent impairments
  - non-economic loss (NEL) benefit compensating for reduced enjoyment of non-work-related aspects of life (Vol. 3 No. 5, Vol. 4 No.'s 1, 5, 8, Vol. 7 No. 6)
  - future economic loss (FEL) benefits paid to age 65, compensating for loss of earning capacity (Vol. 4 No.'s 1, 5, 6, Vol. 8 No. 4)
- retirement income benefit paid after age 65, compensating for loss of retirement income (Vol. 9 No. 2)
- vocational rehabilitation services provided to workers on a timely basis (Vol. 4 No. 4, Vol. 3 No. 2)
- maximum amount of average earnings covered each year is 175 per cent of the average industrial wage (AIW) for Ontario, starting in January 1992



# m 1984 to 1995

## Bill 162 - 1989 (cont'd)

### Employer obligations

- employers obliged to re-employ workers (Vol. 3 No. 1, Vol. 4 No's 1, 3, 6)
- employers continue contributions to employment benefits (Vol. 3 No.1)

## Bill 165 - 1994

### Board of directors

- bi-partite board of directors (equal representation from labour and business)

### Purpose clause

- clause added to the *Act* to:
  - provide fair compensation and health care benefits
  - provide rehabilitation services to workers to facilitate return to work
  - provide rehabilitation services to survivors
  - require the board of directors to act in a financially responsible and accountable manner

### Indexing

- indexing factor based on 75% of CPI, less 1% with a cap of 4% ("Friedland formula"), full CPI indexing continues for specific benefits (Vol. 8 No's 1, 2, 4)

### Benefits/coverage

- additional benefit of up to \$200/month for pension recipients entitled to supplement equivalent to old age security benefit (Vol. 8 No's 1, 3)
- workers and employers to work in partnership with health professionals and the WCB to foster return to work (Vol. 8 No. 1)
- WCB provides mediation and dispute resolution services (Vol. 8 No. 1, Vol. 9 No. 3)
- WCB determines on its own initiative, whether employers have met their re-employment obligations (Vol. 8 No. 1)

### External bodies

- Industrial Disease Standards Panel renamed the Occupational Disease Panel

## Bill 15 - 1995

### Board of directors

- multi-partite/multi-stakeholder board of directors
- annual value for money audit (Vol. 9 No. 1)

### Purpose clause

- clause amended to include
  - prevention and reduction of injuries (Vol. 9 No. 1)
  - promotion of health and safety in the workplace

### Memorandum of understanding (Vol. 9 No. 1)

- MoU with Minister of Labour consisting of
  - annual strategic plan
  - annual statement of priorities for administering *Act* and regulations
  - annual statement of investment policies and goals

### Collection of debts (Vol. 9 No. 1)

- overpayments become debts due and owing to the WCB (Vol. 9 No. 4)
- debts may be recovered from money payable (Vol. 9 No. 4)

### Employer/worker obligations

- employers obliged to register within 10 days (Vol. 9 No. 1)
- material change in circumstances must be reported to the WCB within 10 days for both employers and workers (Vol. 9 No. 4)
- offences and penalties grouped in Part V of the *Act* (Vol. 9 No. 4)

## Highlights of pre-'85 compensation changes

1914 - *Workmen's Compensation Act* (came into effect Jan. 1. 1915)

1918 - coverage expands to include medical aid

1924 - coverage expands to include vocational rehabilitation

1953 - experience rating plan introduced

1963 - definition of accident expands to include "disablement arising out of and in the course of employment"

1983 - name change to *Workers' Compensation Act* and Workers' Compensation Board

Note: This list is not exhaustive.

# Revised payment schedule

## Reduces benefit-related debt creation

The WCB has changed its schedule for mailing temporary benefit cheques. Until recently, the WCB would, for example, mail a cheque Friday that paid a worker up to the following Wednesday, so the worker would receive the money by the end of the two-week pay period. This sometimes led to the creation of benefit-related debts, because a worker might return to work after his cheque was mailed, but before the pay period had ended.

To solve this problem the WCB has introduced the "One Week in Arrears" initiative. It establishes the mailing of temporary benefit cheques one week later than before, giving the WCB time to obtain return-to-work information and adjust, or stop, payments appropriately before the cheque is mailed. Avoiding benefit-related debt creation saves the WCB the cost of recovering debts, and saves workers the inconvenience of repaying them.

This new payment initiative only applies to workers injured on or after April 1, 1997.

### Example A - Injury before April 1, 1997 (old schedule)

Neil was injured on March 7, 1997. On March 17, his adjudicator authorized payment for two weeks, from March 8 to 22. His cheque was mailed on March 18.

On March 21, 1997 Neil returned to work and advised his adjudicator. The adjudicator explained to Neil that a debt would be created for the extra day he was paid, and followed this up with a letter requesting he repay the debt.

## March

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

*payment period*

*cheque due*

### Example B - Injury on or after April 1, 1997 (new schedule)

Nan was injured on April 7, 1997 and went off work on April 8. On April 17, Nan's adjudicator authorized payment for two weeks, from April 8 to 22. Her cheque was not to be mailed until April 25.

On April 21, Nan returned to work. She advised her adjudicator right away. Because Nan's cheque had not been issued yet, her adjudicator was able to adjust it to pay up to April 21. As a result, no debt was created in Nan's claim.

## April

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

*payment period*

*cheque due*

### Interest

The WCB continues to pay interest on cheques that are not mailed by the standard payment due date.

For more information call Payment Services at (416) 344-2702.



# The legislative process & Bill 99

## First Reading

Bill 99, the government initiative to reform the Ontario workers' compensation system, was presented to the Legislative Assembly last November. At that time it went through what is called "first reading": its title and a summary of its contents were read to the House. Although the bill has the support of the majority government, it must pass through the legislative process to become law.

## Second Reading

On April 23, the government took the next step in the process and moved "second reading" in the Legislative Assembly. The Assembly may now refer it to committee — either the Committee of the Whole House, or the all-party Standing Committee on Resources Development.

## Public Hearings

The committee decides if there will be public hearings, and if so, where and when they are to be held. The committee also reviews the bill clause by clause. During this phase,

committee members and the government can present motions to amend the bill.

## Third Reading

When the committee is finished its work, it makes a report to the Legislative Assembly. The House considers the report, and the government moves "third reading," at which time a vote is taken on the bill.

## Royal Assent

If the bill passes the vote, the Lieutenant Governor signs it (this is called "Royal Assent") and it becomes law.

The new law is effective from its proclamation date — this may be the date it receives Royal Assent, a date named by the Lieutenant Governor, or another specified date.

*Copies of the bill are available from Publications Ontario, which can be reached at (416) 326-5300 or 1-800-668-9938.*

# Provincial tax-cut increases some benefits

As announced in the recent provincial budget, the personal tax rate for Ontario will drop 1% **retroactive** to January 1, 1997. Because the cut becomes effective on July 1, 1997, its true value for the balance of 1997 will be 2%. So, even though CPP premiums will be increasing slightly as of July 1, 1997, the tax cut is still good news for workers receiving some compensation benefits. Here's why.

The WCB calculates most benefits based on 90% of a worker's pre-injury net average earnings (NAE).<sup>\*</sup> The WCB determines NAE by deducting from the worker's gross earnings the probable CPP/QPP premiums, Employment Insurance premiums, and income tax payable by the worker.

Probable income tax payable is based on federal and provincial income taxes. A decrease in the provincial personal tax rate results in a decrease in the probable income tax payable. A smaller deduction for probable income tax means a larger NAE amount, and may result in an increase in compensation.

The WCB expects that in most cases, the amount of the tax cut will exceed the increase in CPP premiums.

## Benefits affected

Workers may see a small increase in the following WCB benefits if their payments span, or start on or after, July 1, 1997

- all benefits for accidents between April 1, 1985 and January 1, 1990 (inclusive)
- temporary disability benefits for accidents that occurred on or after January 2, 1990
- supplements as a result of accidents on or after January 2, 1990, and
- monthly dependant benefits for deaths on or after April 1, 1985.

Future economic loss (FEL) benefits first paid after July 1, 1997 will be calculated using the new provincial personal tax rate. FEL benefits reviewed after July 1, 1997, may be affected by the new tax rate.

## Benefits not affected

The following compensation benefits are not affected by the tax cut

- all benefits for accidents before April 1, 1985
- Bill 162 Old Age Supplement benefits [s.43(8)]

*continued on page 6*

<sup>\*</sup> *Benefits for accidents before April 1, 1985 are based on 75% of a worker's pre-injury gross earnings.*

## Policy Report (cont'd from p.1)

It also includes a record of how these categories have been amended since 1993, and the authority for those changes. The ECM is updated regularly, as the classification scheme is revised and refined to capture current business activities.

The *WCB Bilingual Lexicon* contains approximately 2,200 terms used by various operating areas of the WCB, as well as some used in other WCB-related fields such as medicine and finance, which may not be found in general bilingual dictionaries. The Lexicon translates these terms from English to French, and French to English.

We hope you enjoy reading *Policy Report*, and we look forward to continuing to provide you with plain-language analysis of WCB legislation and policies into the next millennium!

## Provincial tax cut (cont'd from p.5)

- non-economic loss benefits (NEL)
- burial benefits, and
- lump sum payments made to dependants.

The WCB will inform workers whose benefits may increase as a result of the new tax rate, by letter.

(See Bill 81- 1985, on page 2.)

### Maximum annual earnings covered 1915 - 1987

Effective date	Indexing factor	Maximum yearly amount
Jan. 1, 1915	n/a	\$2,000
July 1, 1943	n/a	\$2,500
Jan. 1, 1950	n/a	\$3,000
Jan. 1, 1952	n/a	\$4,000
Jan. 1, 1957	n/a	\$5,000
Jan. 1, 1963	n/a	\$6,000
Aug. 1, 1968	n/a	\$7,000
Aug. 1, 1971	n/a	\$9,000
July 1, 1973	n/a	\$10,000
July 1, 1974	n/a	\$12,000
July 1, 1975	10%	\$15,000
July 1, 1978	8%	\$16,200
July 1, 1979	10%	\$18,500
July 1, 1981	10%	\$22,200
July 1, 1982	9%	\$24,200
July 1, 1983	5%	\$25,500
July 1, 1984	5%	\$26,800
July 1, 1985	5%	\$28,200
Jan. 1, 1986	1.7%	\$28,700
Jan. 1, 1987	4.4% (CPI)	\$30,000

Automatic annual indexing based on CPI starts in 1987.

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July 31, 1997

Dear Reader:

We in Policy Publications are committed to providing you with plain language information about the policies used by WCB decision-makers. Our goal is to make workers' compensation legislation, and the policies that flow from it, accessible to everyone. *Policy Report* is an important tool used in achieving that goal.

With this in mind, we would like your help. Please take a few minutes to complete the *Policy Report* Reader Survey on the back of this page, and fax it to Policy Publications at:

(416) 344-4333 or 1-800-424-1459, or mail it to:

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Workers' Compensation Board  
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Your input can help us achieve our goal. Thank you for helping us provide the best product possible.

Sincerely,

David Williams  
Managing Editor



## 1997 Reader Survey

Please rate *Policy Report* on each of the following characteristics:

	Poor			Excellent	
Readability	1	2	3	4	5
Interest	1	2	3	4	5
Usefulness	1	2	3	4	5
Appearance	1	2	3	4	5

Do you find there is too little, or too much information in *Policy Report* articles? Please explain.

How can we improve *Policy Report*?

Are there any topics that you would like to see covered in *Policy Report*?

Thank you for your comments. Please fax this survey back to us at:

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Other Workers' Compensation Jurisdiction ☐

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Other (please specify) \_\_\_\_\_



# POLICY REPORT

Volume 11, Number 2 April 1998

**WSIB**  
**CSPAAT**

Workplace Safety &  
Insurance Board

Commission de la sécurité  
professionnelle et de l'assurance  
contre les accidents du travail

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- LOE - Notice of change ..... 5
- Retirement pension ..... 6
- Material change ..... 6
- Calling the WSIB ..... 7-8
- Job-search update ..... insert

## Understanding the Loss of Earnings benefit

The loss of earnings (LOE) benefit is the cornerstone of the Board's benefit scheme under the new Act. It is the basic benefit paid to insured workers who experience a loss of earnings due to a workplace injury\* that occurs on or after January 1, 1998.

### How is it calculated?

The Board uses 2 formulas to calculate LOE benefits. The formula used depends on the worker's

- level of disability, i.e., ability or inability to work, and
- employment status, i.e., whether working or not.

#### Full LOE benefits



Workers who are entirely unable to work due to their injury, or who have not returned to work but are co-operating in health care and participating in early and safe return to work (ESRTW) or labour market re-entry (LMR) activities, are eligible for the full LOE benefit. This equals 85% of the worker's pre-injury net average earnings (NAE), i.e., the worker's average earnings (up to the maximum) minus deductions for the Canada Pension Plan (CPP), Quebec Pension Plan (QPP), Employment Insurance (EI), and income tax. Therefore, the formula for full LOE benefits is:

$$\text{pre-injury NAE} \times 85\% = \text{full LOE benefit}$$

**Example:** Joe was injured in January 1998. His pre-injury gross earnings were \$454.00/week. Using net claim code 01,\*\* Joe's NAE is \$352.94. Since he is entirely unable to work due to his injury, the Board calculated Joe's LOE benefit by multiplying his NAE by 85%.

$$\$352.94/\text{week} \times 85\% = \$300/\text{week (full LOE benefit)}$$

#### Partial LOE benefits

Workers who return to work at a wage loss and those who are ready to return to work following an LMR assessment or plan, are entitled to LOE benefits calculated using the following formula:

$$(\text{pre-injury NAE} - \text{post-injury NAE}) \times 85\% = \text{partial LOE benefit}$$

**Example:** Joe's pre-injury NAE was \$352.94/week. When he returns to work at reduced hours he is paid \$150/week (\$142.50 net) by his employer. To calculate Joe's LOE benefit for the period he is on reduced hours, the Board subtracts Joe's post-injury net earnings from his pre-injury net earnings, and multiplies the result by 85%.

$$(\$352.94/\text{week} - \$142.50/\text{week}) \times 85\% = \$178.87/\text{week (partial LOE benefit)}$$

\* In this article, "injury" includes disease.

\*\* Net claim code 01 is used for all examples.

**Partial LOE benefits  
(cont'd)**

Post-injury NAE may be actual earnings or, if there are no actual earnings available, they may be earnings the Board deems the worker able to earn in a suitable employment or business. The Board uses actual earnings for workers who return to work,\* and deemed earnings for workers who complete an LMR assessment or plan and are ready to return to work in the general workforce.

**CPP/QPP  
disability benefits**

If a worker receives CPP/QPP disability benefits due to the workplace injury, the Board considers those benefits to be post-injury earnings.

**The minimum  
& maximum**

LOE benefits are subject to the minimum and maximum amounts set out in the Act.

In 1998, the weekly minimum is \$294.64. In most cases, if a worker's full LOE benefit falls below the minimum, the Board uses the minimum itself as the level of the benefit. However, if a worker's NAE is below the minimum, the Board uses the NAE as the level of the benefit.

Example: Mena was earning \$400/week gross (NAE = \$314.54). Her full LOE benefit (85% of NAE) comes to \$267.36. Since this is below the minimum, her LOE benefit is set at the minimum: \$294.64/week.

Nelson was earning \$250/week gross (NAE = \$208.91). Since Nelson's NAE is below the minimum, his full LOE benefit is equal to his NAE: \$208.91/week.

The weekly maximum gross earnings covered in 1998 is \$1119. If a worker's pre-injury gross earnings exceed the maximum, the Board substitutes the maximum for the worker's actual gross earnings, to calculate LOE benefits.

Example: Susan was injured in February 1998. She was earning \$1300/week. To calculate Susan's full LOE benefit, the Board would use \$1119 (NAE = \$762.28) instead of her actual gross earnings, and multiply the NAE by 85%.

$\$762.28/\text{week} \times 85\% = \$647.94/\text{week}$  (full LOE benefit, at maximum)

**When do LOE  
benefits start?**

The accident employer must pay the worker's wages for the day of injury. The Board starts payment of LOE benefits on the day following the day of injury, or whenever the worker starts to experience a wage loss as a result of the injury.

**What must  
workers do?**

Workers must file a claim with the Board and consent to the release of functional abilities information to be considered for LOE benefits. Workers who receive benefits are required to

- provide the Board with information necessary to adjudicate the claim, e.g., earnings information
- co-operate in health care as recommended by the treating health-care practitioner
- co-operate in activities designed to facilitate an ESRTW with the accident employer, or in some cases,
- co-operate in an LMR assessment and plan to assist in their re-entry into the general labour market.

If workers do not co-operate as required, their benefits may be reduced or suspended.

\* In these cases, the Board may conduct an LMR assessment to determine if the worker could lessen the wage loss by working elsewhere.



**Material change**

Workers are also required to report to the Board, within 10 days of when it occurs, any material change in circumstances the worker experiences while receiving benefits or services.

A material change is one that may affect a worker's entitlement to benefits and services under the Act. It may be a change in the worker's

- medical condition or treatment
- income
- employment status (including finding a job, being terminated, retiring)
- employment conditions (including hours of work, wages, duties, etc.)
- ability to co-operate with the Board (e.g., if a worker is leaving the province, being imprisoned, incapacitated by an unrelated health condition), and
- earnings affecting his or her optional insurance coverage.\*

Changes to entitlement to LOE benefits\*\* are effective from the date the material change occurred. Workers who are late to report an increase in their earnings may end up with a benefit-related debt.

**Wilfully** failing to report material change to the Board may result in penalties under the *Provincial Offences Act*, or prosecution for fraud under the Criminal Code.

## When do LOE benefits stop?

**Material change**

If a worker's earnings increase so that there is no longer a loss of earnings, the Board stops the benefit on the day the worker's earnings were fully restored.

**Recovery**

If a worker's health care practitioner advises the worker to return to regular work, benefits are terminated the following day.

**"Zero NEL"**

If the Board determines that a worker has no remaining impairment through a non-economic loss (NEL) assessment, i.e., the NEL is rated at 0%, the Board continues to pay the LOE benefit for up to 2 weeks, until the worker is notified of the NEL rating, and that the LOE benefit is no longer payable.

**Payable term ends**

In most cases, LOE benefits can only be paid up to the end of the month in which the worker reaches age 65. However, workers who are 63 or older at the time of injury, and who do not elect the "no review" option (see p 4.), can be paid LOE benefits for **up to** 2 years from the date of accident, as long as they remain entitled because of the injury. In these cases, the Board stops the benefit payment at the end of the month in which the 2-year point is reached.

## When are LOE benefits reviewed?

**Material change reviews**

The LOE benefit review system is largely driven by material change-reporting. An LOE benefit is reviewed whenever a material change is reported, up to 6 years (72 months) post-injury. After that, the amount of the benefit is fixed, unless the worker failed to report a material change that occurred before the claim reached the 6-year mark.

\* This list is not exhaustive.

\*\* See the companion article on p.6 for other benefits affected by material change.

### **The 24-month variable review**

The Board also reviews LOE benefits if, at any time during the first 6 years of the claim, a period of 24 months of continuous payment passes in which no benefit review has taken place.

### **Final review**

The final LOE review takes place shortly before the 6-year mark, to ensure that the benefit is accurate before it is locked in. When a claim in which LOE benefits are being paid reaches 63 months post-injury, (5 years and 3 months) the Board requests earnings and employment status information from the worker. The Board sends 2 follow-up notices. If the worker does not provide the necessary information by the 67th month, benefits are withheld until the worker contacts the Board. If the worker does not provide the information by the end of the 72nd month (6th year), the worker's LOE benefit is locked in at \$0, i.e., the Board makes no benefit payment. This can only be adjusted if the worker later reports a material change that occurred before the end of the 72nd month.

### **Older workers & the "no review" option**

In the first 6 years of a claim, LOE benefits are re-viewed whenever a material change is reported, and after 24 months if there has not been a material change review in that period.

Older workers may direct the Board **not to** review their LOE benefits if

- they are 55 or older when the Board determines they are entitled to LOE benefits
- their medical condition is unlikely to show further improvement, i.e., they have reached maximum medical recovery (MMR), and
- they have completed an LMR plan.

For workers who elect this option, the material change-reporting obligation ceases. The Board will not adjust their LOE benefits, even if there is a material change or a recurrence.

The Board informs workers when they become eligible for the "no review" option. Workers may only exercise this option within 30 days of when they meet all 3 criteria. Once a worker exercises this option, it cannot be reversed.

Note: Workers who are 63 or older at the time of injury, and who might otherwise be entitled to LOE benefits for up to 2 years from the date of injury, only receive LOE benefits until they reach age 65 if they exercise the "no review" option. This option is not available to workers over age 65.

### **When does the Board adjust the LOE benefit?**

#### **The 5% threshold**

The Board only adjusts an LOE benefit if there is a significant material change. To determine if a material change is significant, the Board compares the post-injury (escalated) gross earnings being used to pay the benefit, to the newly reported gross earnings. If the difference is 5% or greater, the Board adjusts the benefit.

Example: Phil is receiving an LOE benefit based on his post-injury gross earnings of \$300/week. Since 5% of \$300 is \$15, Phil would have to experience an increase or a decrease in earnings of at least \$15 for it to have an effect on his benefit.

If a worker's earnings decrease, the Board only adjusts the LOE benefit if the decrease is significant (greater than the 5% threshold) **and** if it can be attributed to the workplace injury, such as if

- the worker suffers a recurrence of the injury
- the worker's condition deteriorates and, as a result, the worker has to take a lower paying job, or
- the worker's job changes due to the injury, resulting in lower pay.



## **Exceptions**

There are 2 exceptions to the 5% threshold. The first concerns CPP/QPP benefits. The Act requires that LOE benefits be adjusted to reflect any CPP/QPP disability benefits the worker receives as a result of the workplace injury. When CPP/QPP disability benefits are first reported to the Board, or when a change in these benefits is reported, the Board must adjust the LOE benefit even if the change is less than 5% of the worker's pre-injury gross earnings.

The second exception concerns recovery of full earnings. The Act requires the Board to stop paying LOE benefits once the worker no longer has a loss of earnings. When this occurs, the Board does not use the 5% threshold.

## **How often do workers receive LOE benefit payments?**

### **Commutations**

In the first year after the injury, the Board pays LOE benefits bi-weekly. From that point on they are paid monthly, and can be paid by direct deposit at the worker's request.

An LOE benefit that is less than or equal to 10% of what the worker would receive on full LOE benefits may be commuted to a single lump sum payment. Most workers who qualify for commutations are given this option once their benefit is locked in, at 6 years post-injury. The Board sends them a letter which explains the option, and provides the value of the commuted benefit. These workers receive 2 monthly payments after the letter is mailed. If they do not indicate a preference to stay on monthly payments during that period, the Board commutes the benefit and pays it as a lump sum.

Older workers who elect not to have further LOE reviews (see page. 4) may be offered a commutation shortly after they make that election.

## **Recurrences**

The Board can only pay LOE benefits for recurrences that occur within 6 years of the original injury, or in occupational disease claims, within 6 years of either the date the worker laid off work, or the date of diagnosis. Nevertheless, workers who experience a recurrence after the 6-year point may be entitled to further health care and, in some cases, to a NEL re-determination.

## **Notice of change to LOE policy**

The policy entitled "Payment of LOE Benefits," published in January 1998, provided 2 ways to calculate LOE benefits for workers who are working.

For most workers, the policy instructed decision-makers to calculate the benefit by subtracting the worker's current NAE from pre-injury NAE, and to pay the worker 85% of the difference.

However, for workers who were working while co-operating in ESRTW activities, or an LMR assessment or plan, the policy instructed decision-makers to calculate the benefit by subtracting current earnings from the amount the worker would be eligible to receive on full LOE benefits. As a result, these workers would receive lower benefits than those who were working but not involved in ESRTW or LMR.

The Board has reconsidered this policy and decided not to use the second calculation method because it set up a financial disincentive to co-operating in return to work programs.

This change was made on March 19, 1998, and is effective from January 1, 1998. The Board will adjust the LOE benefits of workers whose benefits were originally calculated using the second method.

## Retirement pension set-aside reduced to 5%

Under the old Act, the Board sets aside an amount equal to 10% of all future economic loss (FEL) benefits to create a retirement fund. When eligible workers reach age 65, their FEL benefits stop and their retirement pensions begin.

Although the new Act replaces temporary disability benefits and FEL benefits with LOE benefits, the retirement pension remains in place. For workers who receive LOE benefits for more than 12 continuous months, the Board now sets aside an amount equal to 5% of the LOE benefit, and the worker has the option of matching that with another 5%. This only applies for accidents occurring on or after January 1, 1998.

## Material change

### What other benefits are adjusted when a worker experiences a material change?

Although the Board has always expected employers and workers to report changes affecting benefits, classification, premiums, and services, the concept of "material change" was only formally introduced into the Act in December 1995, with Bill 15.

Material change-reporting is the main trigger for LOE reviews, as discussed on page. 3, but it also affects the benefits listed below

- temporary disability benefits (in claims with accident dates from January, 1990)
- non-economic loss (NEL) benefits
- future economic loss (FEL) benefits
- dependants (survivors) benefits (in claims with accident dates from January, 1990), and
- pension supplements [under sections 147(2), (4), and (14) of the pre-1998 Act].\*

Workers receiving any of these benefits are required to report any material change within 10 days of when it occurs.

\* This list is not exhaustive.

# POLICY REPORT

**WSIB**  
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Workplace Safety &  
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contre les accidents du travail

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# Calling the WSIB (April 1998)

*When you need to call the Board, save time by dialing direct.*

**Enquiring about a claim** - Claims are administered according to the sector or district office. The last digit/letter of a claim number, following the dash, indicates where it is handled.

Sector .....	local # .....	toll free #
- 1, Automotive, Food .....	(416) 344-1001 .....	1-800-263-8877
- 2, Chemical, Education, Electrical Utilities, Municipal, Schedule II .....	(416) 344-1004 .....	1-800-387-0080
- 3, Services, Agriculture, Small Business (Toronto) .....	(416) 344-1007 .....	1-800-387-0068
- 4, Construction .....	(416) 344-1004 .....	1-800-387-0080
- 5, Transportation, Health Care .....	(416) 344-1002 .....	1-800-387-0066
- 6, Manufacturing .....	(416) 344-1005 .....	1-800-387-0025
- 7, No Lost Time claims .....		1-800-565-4253
- 8, Paper claims (Pre-Bill 162) .....	(416) 344-1008 .....	1-800-387-0080
- Z, Serious Injuries Programme .....	(416) 240-7240 .....	1-800-387-1433
- O, Complex Cases (Diseases) .....	(416) 344-1010 .....	1-800-465-9646
<b>District Offices</b>		
- H, Hamilton .....	(905) 523-1800 .....	1-800-263-8488 (416, 905, 519, 613, 705)
- L, London .....	(519) 663-2331 .....	1-800-265-4752
- Q, Ottawa .....	(613) 238-7851 .....	1-800-267-9601 (Ontario & Quebec)
- S, Sudbury .....	(705) 675-9301 .....	1-800-461-3350
- U, Thunder Bay .....	(807) 343-1710 .....	1-800-465-3934
- W, Windsor .....	(519) 966-0660 .....	1-800-265-7380

If your claim number ends in -T, or if you cannot find a number on this list, call (416) 344-1000, 1-800-387-0750 (On) or 1-800-387-5540 (Ca).  
To find out if a claim has been registered, call Central Claims Processing at (416) 344-3801, 1-800-387-0750 (On) or 1-800-387-5540 (Ca).

## Area Offices

Kingston .....	(613) 544-9682 .....	1-800-267-9461 (613)
Kitchener-Waterloo .....	(519) 576-4130 .....	1-800-265-2570
North Bay .....	(705) 472-5200 .....	1-800-461-9521 (Ontario & 819)
Sault Ste. Marie .....	(705) 942-3002 .....	1-800-461-6005 (705)
St. Catharines .....	(905) 687-8622 .....	1-800-263-2484
Timmins .....	(705) 267-6427 .....	1-800-461-9856 (705 & 819)

## Enquiring about an account

• accident cost statements .....	(416) 344-1016 .....	1-800-663-6639
• audits .....	(416) 344-3628 .....	1-800-387-5674
• clearance certificates .....	(416) 344-1012 .....	1-800-387-8638
• collections .....	(905) 521-4404 .....	1-800-268-0929 1-800-268-6045
• experience rating, Workwell .....	(416) 344-1016 .....	1-800-663-6639
• obtaining an organizational test questionnaire, registering a business, reporting or paying premiums .....	(416) 344-1013 .....	1-800-387-8638

\* Most of the toll free numbers listed above can be reached from anywhere in Ontario. Those which cannot, have the area(s) or area code(s) from which they can be reached in brackets after the number.



# Calling the WSIB (April 1998)

For information on .....	area code 416 .....	toll free #
• 'access' i.e., claim file copies (call district or sector)		
• appeals/mediation ( <b>Appeals Branch</b> )	344-1014	1-800-387-0773
• assignment of no-fault insurance benefits, lawyer-on-call, support deductions, third-party elections/forms, or the <i>Freedom of Information and Protection of Privacy Act</i> ( <b>Legal Branch</b> )	344-2953	1-800-387-0750
• certification training, first aid regulations, WSIB incentives	344-1016	1-800-663-6639
• the form 7 ( <i>Employer's Report of Injury/Disease</i> )		
- to submit by fax	344-4684	1-888-313-7373
- to get approval of a facsimile form 7	344-3792	1-800-387-0750
• health care agencies		
- account processing	344-1019	1-800-387-0750
- registration	344-2937/6/5	1-800-387-0750
• health and safety training, safe workplace associations, transfer of costs ( <b>Prevention Division</b> )	344-1016	1-800-663-6639
• the <i>Occupational Health and Safety Act</i> ( <b>Ministry of Labour</b> )	326-7770	1-800-268-8013
• policies (ask for the analyst-on-call)		
- benefits	344-4330	1-800-387-0750
- revenue	344-4150	1-800-387-0750
• service in French or other languages ( <b>Language Services</b> )	344-2000	1-800-387-0750
• statistics ( <b>Corporate Data</b> )	344-4700	1-800-387-0750

## To receive

• a copy of the Act ( <b>Publications Ontario</b> )	326-5300	1-800-668-9938
• brochures, first-aid requirements booklet, reports, etc. ( <b>Communications</b> )	344-4200	1-800-387-0750
• <i>Employer Classification manual, Operational Policy manual, Policy Report</i>	344-4355	1-800 387-0750
• forms ( <b>Order Desk</b> )	344-3862	1-800-387-0750
• health care billing cards	344-2937/6/5	1-800-387-0750

## To reach

• Communications - media enquiries	344-4768	1-800-387-0750
• Special Investigations Branch Action Line ( <i>calls can be anonymous</i> )		1-888-SI-LEADS
		1-888-745-3237
• TTY line for the hearing impaired		1-800-387-0050
• WSIAT ( <b>Appeals Tribunal</b> )	598-4638	
• WSIB library	344-4052	1-800 387-0750

## On-line

- Special Investigations: E-mail address: [sileads@wsib.on.ca](mailto:sileads@wsib.on.ca) - Web site address: [www.wsib.on.ca](http://www.wsib.on.ca)
- WSIB: E-mail address: [wsibcomm@wsib.on.ca](mailto:wsibcomm@wsib.on.ca) - Web site address: [www.wsib.on.ca](http://www.wsib.on.ca)

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# Job-search update

Recently, there has been some confusion about job-search entitlement for pre-1998 claims in which the worker was entitled to, or involved in, vocational rehabilitation (VR) services, but had neither started a Board-sponsored job search, nor had any written commitment on file for job-search assistance from the Board.

The Board will honour all pre-January 1, 1998 commitments to sponsor workers during a job-search phase, including claims in which verbal commitment was made but not documented on file, or where no explicit commitment was made but a job search is necessary and reasonable. This provision also applies for workers with pre-1998 claims who request VR services after January 1, 1998.

The issue of how much job search the Board will sponsor depends on the specifics of the claim, determined on a case-by-case basis.

Section 53(12) and (13) of the *Workers' Compensation Act* (WCA) provided for a worker's VR program to include up to 6 months of job-search assistance, with a possible extension of up to 6 more months, at the request of the worker, the employer, or on the Board's own initiative. The duration of job-search sponsorship was determined by the decision-maker in consultation with the worker, and was dependent upon the specifics of the claim, the worker's needs, and entitlement.

For workers who were active with VR through January 1, 1998, the transitional provisions of the *Workplace Safety and Insurance Act* (WSIA) apply. Section 108 of the WSIA provides that VR assessments and/or services under the WCA are deemed to be either early and safe return to work (ESRTW) programs, or labour market re-entry (LMR) plans, as of January 1, 1998. This means that all claims active with VR on January 1, 1998 were converted to ESRTW or LMR, and services are being continued in accordance with s.40 and s.42 of the WSIA and related policies.

## Appeals

When an appeal of a pre-1998 decision is resolved in favour of the worker, resulting in entitlement to VR assistance before January 1, 1998, the worker has entitlement under s.53 of the WCA and related policies. If entitlement continues on and after January 1, 1998, service is continued under s.40 and s.42 of the WSIA and the transitional policies implemented on January 1, 1998.





# POLICY REPORT

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contre les accidents du travail

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## Adjudicating **Mental Stress**

We all deal with stress every day, but if we laid off work due to stress, would the WSIB allow the claim? Can a worker get benefits for being off work due to chronic stress from a heavy work load, or a demanding supervisor? How about if the stress was caused by a traumatic event? In January of this year the Board introduced a new policy on mental stress that answers these questions.

The new mental stress policy expands on the wording of the Act (see below) and formalizes the past practice of the Board. It is one of three Board policies dealing with entitlement for psychological conditions. The other two deal with psychotraumatic disability, and chronic pain disability. Together, these three policies cover a wide range of work-related psychological conditions. This article discusses the new mental stress policy in detail, and looks at how it fits in with psychotraumatic disability and chronic pain.

### What does the Act say?

The new Act includes language on mental stress for the first time. The following is found in section 13.

- (1) A worker who sustains a personal injury by accident arising out of and in the course of his or her employment is entitled to benefits under the insurance plan.
- (4) Except as provided in subsection (5), a worker is not entitled to benefits under the insurance plan for mental stress.
- (5) A worker is entitled to benefits for mental stress that is an acute reaction to a sudden and unexpected traumatic event arising out of and in the course of his or her employment. However, the worker is not entitled to benefits for mental stress caused by his or her employer's decisions or actions relating to the worker's employment, including a decision to change the work to be performed or the working conditions, to discipline the worker or to terminate the employment.

This wording makes it clear that the Board only allows claims for mental stress if the stress is an "acute reaction to a sudden and unexpected traumatic event." This does not include an employer's work-related decisions or actions. The new mental stress policy uses examples to illustrate what the Board views as an acute reaction to a sudden and unexpected traumatic event.

### "Acute" vs. "gradual"

The Board only allows claims for mental stress when the condition develops as an acute reaction. Workers who develop mental stress gradually over time due to general workplace conditions are not entitled to benefits.

Not all acute reactions are immediate. They may be delayed by days, weeks, or months. The Board allows claims in which the acute reaction is delayed if there is clear and convincing evidence linking the reaction to a workplace event.

**Example A:** While at work, John witnesses a serious accident. The next day he calls work to say he is unable to come in because he is so shaken by the event. John's doctor confirms that John is experiencing a great deal of mental stress due to witnessing the accident, and needs a few days off work to recover.

*Is this an acute reaction?*

Yes, John's mental stress is an acute reaction to witnessing the accident. It did not develop gradually.

**Example B:** Bonnie witnesses a serious accident. She shows no symptoms of mental stress for three weeks, and then calls in one morning to say she is unable to work because she is haunted by images of the accident. Bonnie's doctor confirms that she is suffering from mental stress, and recommends treatment and time off.

*Is this an acute reaction?*

Yes, although it was delayed, Bonnie's mental stress was an acute reaction to witnessing a specific event. It did not develop gradually.

**Example C:** Donna works in a highly competitive environment. She is subject to ever-changing deadlines and high performance expectations, all while her company is downsizing. One day she calls in to say the mental stress is too much and she cannot work.

*Is this an acute reaction?*

No, Donna's mental stress developed gradually over time. It is not an acute reaction, and there was no sudden and unexpected traumatic event.

## Sudden and unexpected traumatic events

The Board defines a "traumatic" event as an event that would generally be recognized as traumatic. Traumatic events are usually horrific, or have elements of actual or threatened violence to the worker. For an event to be considered traumatic, it must also be uncommon in the normal course of the worker's employment.

Sudden and unexpected traumatic events include

- witnessing a fatality or a horrific accident
- witnessing or being the object of an armed robbery
- witnessing or being the object of a hostage-taking
- being the object of physical violence
- being the object of death threats or threats of physical violence if the worker has every reason to believe the threat is serious.

Events that would generally not be recognized as traumatic, but which are traumatic to a worker because of the worker's psychological history, are not considered sudden and unexpected traumatic events.

**Example D:** Carolyn sees a co-worker trip and fall, but the co-worker is not hurt. The next day, Carolyn calls in sick due to mental stress caused by witnessing the fall. Carolyn's doctor confirms that she is suffering from mental stress and needs a few days off work.

*Is this a sudden and unexpected traumatic event?*

No, the event Carolyn witnessed would not generally be considered traumatic. That her doctor confirmed she suffers from mental stress, even though there was no sudden and unexpected traumatic event at work, suggests there is another cause for Carolyn's mental stress.



**Example E:** Ron sees a co-worker fall from a great height and sustain serious injuries. The next day, Ron calls in to say he is unable to work due to mental stress. His physician confirms that Ron is suffering from mental stress, and needs therapy and time off. The physician also indicates that Ron's mental stress is due, in part, to his psychiatric history.

*Is this a sudden and unexpected traumatic event?*

Yes, the event Ron witnessed would generally be considered traumatic. That his psychiatric history may have contributed to his reaction is irrelevant since the event at work was traumatic in itself. Ron may have reacted to it in the same way even if he hadn't had psychiatric problems in the past.

### **Other considerations**

The Board may consider an event traumatic even if the worker was exposed to similar events in the past and experienced no ill effects. Also, the Board may consider an event traumatic even if other workers exposed to the same event do not experience ill effects. All workers do not have the same resilience to sudden and unexpected traumatic events.

**Example F:** Jim is a police officer. While investigating a call he encounters a horrific scene involving multiple fatalities. The next day he is unable to work. Jim's physician confirms that Jim is suffering from mental stress. Jim's employer, however, claims that since attending such horrific events is a normal part of police duties, and since Jim has been exposed to many such events in the past without difficulty, Jim's mental stress cannot be due to the horrific scene he recently witnessed.

*Is this a sudden and unexpected traumatic event?*

Yes, the scene Jim witnessed would generally be considered traumatic. Although witnessing such events is part of police work, it is not a normal part of Jim's job. It is not relevant that Jim had experienced similar events in the past without difficulty. Even if there had been other officers with Jim at the scene who were not affected by it, the scene itself would still be considered traumatic.

## **An employer's decisions or actions**

The Board does not allow claims for mental stress due to an employer's decisions or actions that are a normal part of the employment function, such as

- terminations
- demotions
- transfers
- discipline
- changes in working hours, and
- changes in productivity expectations.

However, workers are entitled to benefits for mental stress due to an employer's actions or decisions that are not a normal part of the employment function, such as violence or threats of violence.

**Example G:** Catherine works in a machine shop. One day her employer changes her shift to a time that will not be easy for Catherine to work. When she protests, her employer threatens her with termination. Catherine calls in the next morning to say she is unable to work because of mental stress due to her shift change. Her doctor confirms she is suffering from job-related mental stress.

*Is this an employer's work-related decision?*

Yes, Catherine's mental stress is due to a work-related decision made by her employer, and so does not qualify for benefits.

## **Medical information**

Before the Board can accept a claim, the worker's health care professional must confirm that the worker is suffering from mental stress. The Board requests a formal diagnosis in ongoing cases.

## Comparison to psychotraumatic disability

The key to mental stress entitlement is the nature of the event to which the worker is exposed (sudden, unexpected, traumatic). It is not necessary for there to be a physical injury to the worker. In comparison, entitlement under the psychotraumatic disability policy depends on there being a physical work-related injury that gives rise to a psychological disability.

“Psychotraumatic disability” is a psychological disability caused by an organic (physical) brain condition, or as an indirect result of an injury. It may be an emotional reaction to

- the worker’s accident or injury
- a severe disability
- the treatment of an injury, or
- extended disablement and other factors directly related to an injury.

The Board only recognizes psychotraumatic disability if it manifests itself within 5 years of the injury, or a major surgery.

## Comparison to chronic pain disability

Entitlement for chronic pain disability also requires that there be a physical work-related injury. Chronic pain is pain that

- is caused by the worker’s injury
- lasts for more than 6 months past the usual healing time for the injury
- is worse than expected considering the physical findings, and
- impairs the worker’s earning capacity.

The Board recognizes “chronic pain disability” in workers whose chronic pain causes a marked life disruption, i.e., a clear and distinct disruption of the worker’s personal, working, social, and home life.

For more information on psychotraumatic disability, see OPM 03-03-03. For more information on chronic pain disability, see OPM 03-03-05.

# Which **Act** applies **when?**

Sometimes application dates are straightforward. Typically, a new Act applies to claims with accident dates on or after the date the Act comes into force. With the *Workplace Safety and Insurance Act*, however, it's not that simple.

The new Act came into force on January 1, 1998. While it does apply to all claims with accident dates on or after January 1, 1998, some provisions apply to old claims as well. For pre-1998 claims, check the policy application date—it may depend on factors other than just the accident date.

Because the new Act can affect claims with accident dates before January 1, 1998, we thought it would be helpful to highlight the application dates of some significant policies.

## Benefits payment

Peter, a welder, suffers a work-related back injury on October 3, 1997. He is totally disabled until March 30, 1998.

Benefits payment is one area where the accident date directly determines which Act and policies apply. Because Peter’s accident occurred before January 1, 1998, his benefits are determined under the old Act. They are based on 90% of his net average earnings (NAE), including those benefits paid after January 1998. Had the accident happened in 1998, the Board would have paid Peter loss of earnings benefits instead, which are based on 85% of NAE.



## Vocational Rehabilitation

In September 1997 the Board sponsored Janice in a retraining program at a private institution. She completed the program in March 1998.

The new Act does not provide for vocational rehabilitation (VR) services. They have been replaced with early and safe return to work (ESRTW) activities and labour market re-entry (LMR) assessments and plans. On January 1, 1998, the Board *converted* all active VR services to ESRTW or LMR. On that date Janice's VR plan remained intact but became an LMR plan. Had her accident happened on or after January 1, 1998, the ESRTW and LMR provisions would have applied automatically.

## Future Economic Loss

Norbert's initial FEL determination was made on October 8, 1997.

The Board continues to pay FEL benefits to workers with accident dates before January 1, 1998. However, there are no longer mandatory FEL reviews at 24 months after the initial determination. As of January 1, 1998, FEL benefits are reviewed

- whenever a worker reports a material change in circumstances, **or**
- after 24 months if no material change is reported within any 24 month period (in the first five years after the FEL is determined), **and**
- at 60 months after the FEL is determined.

Even though Norbert's FEL was determined before January 1, 1998, it will be reviewed according to the new policies.

## Non-Economic Loss

On November 30, 1997, Laura was referred for a NEL assessment which took place early in '98.

For NEL assessments, the new Act applies for referrals and requests for redetermination made after January 1, 1998. Laura was referred for a NEL assessment in 1997, so the old Act applies. However, if Laura requests a redetermination the new law and policies apply.

In conclusion, for accidents occurring on or after January 1, 1998 the new Act and related policies apply. For pre-1998 accidents, which Act applies may depend on factors other than the accident date.

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# *New Regulation on* **unpaid training participants**

Under section 17 of Ontario Regulation 175/98 of the new Act, training agencies may now elect to be deemed employers of trainees who they place on unpaid work experience placements. By doing so, any WSIB costs associated with the trainees are charged to the account of the training agency, not the placement employer.

Training agencies that qualify are

- educational institutions, and
- persons, partnerships, organizations, trade unions, and other entities that arrange vocational training or provide vocational services.

For more information, call Revenue Operations at (416) 344-1013 or 1-800-387-8638.

# Survivors' Benefits: *An overview*

There are four benefits and services the Board may provide to survivors of a worker who dies as a result of a work-related injury or disease. They are: monetary benefits (monthly and lump sum), burial expense payment, bereavement counselling, and labour market re-entry assistance.

## Benefits

### Lump sums

Surviving spouses are entitled to a one-time lump sum payment. In 1998, the base amount for this payment is \$56,388.88. To determine how much a spouse is due, the Board

- **subtracts** \$1,409.71 from the base amount for each year the spouse was **over** 40 when the worker died (to a minimum of \$28,194.43), or
- **adds** \$1,409.71 to the base amount for each year the spouse was **under** 40 at that time (to a maximum of \$84,583.30).\*

For example,

- a spouse who was 41 will receive \$54,979.17 ( $56,388.88 - 1,409.71$ )
- a spouse who was 39 will receive \$57,798.59 ( $56,388.88 + 1,409.71$ )

**If there is no spouse**, dependent children under 19 (or under 25 if in an educational program) are entitled to a lump sum of \$56,388.88 to be shared equally. The Board may pay the lump sum on the child's behalf to a parent, guardian, attorney, a Public Guardian and Trustee, or another person the Board considers to be acting in the child's best interest.

### Monthly benefits

A surviving spouse and dependants are also entitled to monthly payments.\*\*

**A surviving spouse with no children** receives a monthly benefit of 40% of the worker's net average earnings (NAE)

- **plus** 1% for each year the spouse was **over** 40 at the time of the worker's death, to a maximum of 60%, or
- **minus** 1% for each year the spouse was **under** 40, to a minimum of 20%.

Once the percentage is determined it is fixed. It does not change as the spouse gets older.

**If a surviving spouse has children**, the spouse is entitled to a monthly benefit of 85% of the worker's NAE at the time of the worker's death.

A child between 19 and 25 who is in an educational program, is entitled to a monthly benefit equal to 10% of the deceased worker's NAE. This continues until the child

- fails to demonstrate regular attendance at school
- stops attending school, or
- obtains a degree, diploma, or certificate from an academic, technical, or vocational post-secondary institution.

This 10% is deducted from the spouse's monthly payment. When the child is no longer entitled to it, it reverts back to the spouse, as long as there continues to be at least one dependent child in the care and control of the spouse.

When the youngest child reaches 19 (or 25 if in school), the spouse's benefits are recalculated for a spouse with no dependent children.

**If the spouse and children are not living together**, the Board divides the monthly payment among the spouse, children, and whoever has the care and control of the children. If the children are not in the care and control of anyone, they receive the difference between the spouse's monthly payment, and 85% of the worker's NAE.

For example, if 85% of a worker's NAE is \$1,700, and the spouse receives \$731/month, a 17 year-old living alone will receive \$969/month (\$1700-\$731).

**If there is no spouse**, and the worker is survived by one dependent child, the child is entitled to a monthly payment equal to 30% of the worker's NAE. When the child turns 19, the payment is reduced to 10% if the child is enrolled in education, otherwise it ceases altogether.

If there is more than one dependent child, the children as a group are entitled to payments equal to 30% of the worker's NAE, plus 10% for each additional child, to a maximum of 85% of NAE.

**A dependent child who is physically or mentally incapable of earning wages** is entitled to monthly payments for life, or until the child is able to earn wages.

If there is no surviving spouse and there are no children, **other dependants** may be eligible for benefits if they can prove they were dependent on the worker. They are only eligible to receive benefits for as long as the worker would reasonably have been expected to provide support. What they are paid depends on their loss resulting from the worker's death. It is capped at 50% of the deceased worker's NAE.

\* These are 1998 figures.

\*\* The Board considers any Canada Pension Plan or Quebec Pension Plan benefits paid to the surviving spouse or dependants when calculating the monthly benefit. The statutory minimum (s.43) applies.



If there is more than one spouse, the lump sum payment and the monthly payments are divided between the spouses. The total lump payments to all spouses may not exceed the maximum for the spousal lump sum, \$84,583.30 in 1998.

A separated spouse is entitled to a lump sum payment and monthly payment as a surviving spouse if

- he or she meets the definition of spouse, and
- immediately before the worker's death, the worker was required to make support payments under a separation agreement or court order, or
- where there is no separation agreement or court order, it can be shown the spouse was financially dependent on the worker when the worker died.

### Burial expenses

The Board pays reasonable burial or cremation expenses. For 1998, the minimum payable is \$2,114.57. The maximum is \$8,650. The Board also pays to transport a worker's body to

the residence of the worker or the immediate family, if it is a considerable distance away.

### Bereavement counselling

The surviving spouse and children are entitled to bereavement counselling to help them adjust to the worker's death and the resulting family and social situation. It must be requested within one year of the worker's death, and may be approved for up to 12 months.

### Labour market re-entry

Spouses are entitled to a Labour Market Re-entry (LMR) assessment to aid in their return to the workforce. This too must be requested within one year of the worker's death. Based on the results of the assessment, the Board may offer the spouse an LMR plan to enhance the spouse's employability.

The information in this article is summarized in a chart on the next page. For more information on survivors' benefits see documents 13-01 through 13-17 in the *Bill 99 Operational Policy* book.

## Ottawa & Guelph Offices on the Move

Need to keep in touch with the Ottawa or Guelph office? Here are their new addresses and phone numbers:

### WSIB Ottawa Office

99 Metcalfe St., Suite 700  
Ottawa, ON K1P 1E8

telephone: (613) 237-8840 toll-free: 1-800-267-9601  
fax: (613) 239-3321

### WSIB, Agriculture Sector

Ministry of Agriculture, Food and Rural Affairs Building  
1 Stone Road W.  
4th floor, South Tower  
Guelph, ON N1G 4Y2

telephone: (519) 826-4650 toll-free: 1-888-259-4228  
fax: (519) 826-4687 toll-free fax: 1-888-266-0071

# POLICY REPORT



Workplace Safety & Insurance Board  
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

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Policy Report is published by the Benefits Policy Branch of the Workplace Safety and Insurance Board. If there is any conflict between information in this publication and the Workplace Safety and Insurance Act or approved policy documents, the Act or the policy governs.

In this publication, the "old Act" refers to the Workers' Compensation Act. The "new Act" refers to the Workplace Safety and Insurance Act.

Benefits Policy also publishes the Operational Policy manual, the Employer Classification manual, and a bilingual lexicon.

To purchase any of these publications, or to receive Policy Report, please call Policy Publications at (416) 344-4355 or 1-800-387-0750.

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fax (416) 344-4333



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# Survivors' Benefits\*

Benefits Worker survived by	Spouse's lump sum	Spouse's periodic payment	Children's lump sum	Children's periodic payment	Education payment	Dependant's payment	Bereavement counselling	LMR assessment
Spouse, no children	\$56,388.88 + or - \$1409.71 for each year the spouse was under/over 40	40% NAE** + or- 1% per year the spouse is over/under 40	not entitled	not entitled	not entitled	not entitled	available on request	available on request
Spouse & Child(ren)		85% of NAE	not entitled	not entitled	children between 19-25 entitled if in school	not entitled	available on request	available on request
Spouse with children living elsewhere	at the time of the worker's death.	85% of NAE - apportioned	not entitled	not entitled	same as above	not entitled	available on request	available on request
Child(ren) no spouse	not entitled	entitled if parent or other person has care & control of the child(ren)	apportioned among children	30% for first child, 10% for each additional child, up to 85%	same as above	not entitled	available on request	not entitled
Other dependants	not entitled	not entitled	not entitled	not entitled	not entitled	up to 50% NAE	not entitled	not entitled
Separated spouse	apportioned if more than one spouse	apportioned if more than one spouse	not entitled	not entitled	children between 19-25 entitled if in school	not entitled	child may be entitled	not entitled

\* These benefits apply if the injury or disease that resulted in the worker's death occurred on or after January 1, 1998.

\*\* NAE = net average earnings (In all cases, the statutory minimum and maximum apply, see the accompanying article for details.)



# POLICY

# REPORT

Volume 11, Number 4 December 1998

**WSIB**  
**CSPAAT**

Workplace Safety & Insurance Board  
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

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JAN 29 1999

## Independent Living Policies to help workers with greatest need

The new Independent Living Allowance policy recognizes that severely impaired workers have additional costs because of their injury/disease. Two others, the Independent Living Devices policy, and the Guide and Support Dog policy were revised to reflect different services and devices now available to enhance the quality of life of these workers.

### New independent living allowance

Retroactive to January 1, 1998, a \$2800 a year independent living allowance will be paid annually to workers with a 100% permanent disability or 60% non-economic loss.

The allowance will help offset the costs of devices under \$250, and services which contribute to workers leading a more independent lifestyle by helping them to

- participate more fully in workplace, family, social, or other personal activities, and
- exercise consumer choice in spending the allowance, without having to provide receipts to the Board.

Examples of services range from painting the interior or exterior of a home to housekeeping, or grass cutting. Other services might include fees for supportive therapy or recreational programs like membership in a fitness club; taxi fares to attend community events; hobby supplies or non-vocational instruction such as "help-line" support for computers, and internet fees.

The Board will continue to pay the allowance at the start of each year, unless a material change affects the worker's entitlement. For example, the annual allowance stops when a worker moves to a long-term care facility such as a hospital, convalescent or nursing home, or dies.

The independent living allowance is also paid over and above the monthly attendant's allowance given to some workers.

### Revised policy for independent living devices over \$250

In addition to the annual allowance, the Board will also pay for independent living devices that cost more than \$250 with one exception: workers cannot apply for a device such as a snow blower, if their allowance could be used to offset the cost of a snow removal service.

Independent living devices help restore a worker's ability to communicate, be mobile, take care of personal hygiene, or prevent further injury or health complications due to the work injury/disease. Below is a non-exhaustive list of examples

- personal computers to enhance communication
- automatic page turners
- "easylift" or "veculator" type chairs
- motorized scooters
- sports wheelchairs
- remote vehicle starters
- specialty/hospital beds.

### Revised guide and support dog policy

The Board's guide dog policy has been expanded to include entitlement to a support animal for workers who are profoundly deaf or have significant mobility needs. Entitlement includes the purchase and training of the guide dog or other support/working animal, and routine maintenance and veterinary care (with appropriate receipts) paid for by the Board. The worker is also entitled to mobility training.

continued on page 6

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# Announcing the 1999 Premium Rates

For the third consecutive year, the Board has lowered the average premium rate for Schedule 1\* employers. The rate for 1999 is \$2.42, down 7% from the 1998 rate of \$2.59. Nearly three quarters of the 215 rate groups in Ontario will be receiving rate decreases in the upcoming year. This means that 150,000 firms will experience lower rates in 1999.

The largest decreases will be felt by employers in

- air transport services (-52%)
- agricultural implements manufacturing (-43%), and
- heavy civil construction (-33%).

## Capping eliminated

For the first time since 1993, all employers will be paying the rate required to fully cover their rate group's costs. In previous years, employers in many rate groups paid lowered rates as a result of the application of maximum limits (caps) on year-to-year changes in rates. These caps prevented many employers with poor or deteriorating health and safety records from bearing the full impact of their accident histories. The Board felt that the removal of the cap would send a stronger message linking poor accident records to higher premiums.

## Setting rates

It is important that employers are classified accurately when the Board sets premium rates each year. Rates for each rate group are based on the group's collective cost experience and are expressed as a dollar amount per \$100 of insurable earnings. In most cases, the lower the group's collective historical costs, the lower the rate.

For most employers, their total annual premium is calculated using their rate group premium rate and their insurable earnings, without taking into account their individual accident record. Employers with better than average accident histories can benefit from the Board's accident incentive programs by receiving refunds. However, for employers enrolled in the Merit Adjusted Premium (MAP) program, their individual accident record is already built into their premium rate. (See companion article, *Accident Prevention Incentive Programs ... in 1999 and Beyond*)

\* Schedule 2 employers pay the full costs of their claims, plus an administrative fee.

## Classifying employers

The Board's classification scheme for Schedule 1 divides employer operations in Ontario into nine industry classes. These industry classes are divided into 215 rate groups and are further divided into more than 800 classification units (CUs). Once an employer is registered, the Board records the business activities, assigns CUs, and classifies the employer in the appropriate rate group(s). The Board's decision is based on the employer's description of their business activities.

To ensure accurate classification, the Board may consider various related factors, including the employer's

- business contracts
- direct competitors
- equipment used, and
- staff duties.

## The new funding strategy

Following consultation with the employer community in 1997 and early 1998, the Board adopted a new funding strategy to improve its overall financial footing.

Among other things, the new funding strategy features a commitment to eliminate the unfunded liability (UFL) by 2014. (The UFL is the estimated amount the Board owes now and in the future on all current claims over and above the amount it has the assets to cover.) To eliminate the UFL, the strategy requires that a larger portion of employer premiums be used to pay down the UFL than was done in the past. The strategy also requires that premiums for all rate groups be set at "full target level", i.e., the levels required to cover the full costs of new claims, including administrative costs and UFL charges.

## Funding Safe Workplace Associations

In January 1998, when the new *Workplace Safety and Insurance Act* brought the Safe Workplace Associations into the Board, their funding had to be factored into employer premiums fairly. The Board accomplished this by building the costs for each association into the overhead charged to each of the rate groups using that association. Previously, the costs had been spread on a collective basis across all industries.



# 1999 Facts and Figures

Each year, benefits are indexed by the appropriate indexing factor. For 1999

- the general indexing factor (modified Friedland) is 0%, and
- the alternate indexing factor (Consumer Price Index or CPI) is 1%.

In the first two columns, you will find the section of the Act and the 1997 legislated dollar amount. In the third, you will find the indexed amount for 1999. The amounts that have not changed are the ones that are indexed by the general indexing factor - 0%. For more information about indexing, please refer to the *Operational Policy* manual.

Section	Legislated dollar-amount	1999 \$ - Amount
43(2)	The minimum annual amount for full loss of earnings (LOE) is the lesser of <ul style="list-style-type: none"> <li>• \$15,321.51, or</li> <li>• the worker's net average earnings (NAE) before the injury</li> </ul>	\$15,321.51
45(6)	Retirement pension: Benefit paid as a lump sum if it is less than \$1,142.20/year	\$1,142.20
46	Non-economic loss (NEL) benefit: Base amount = \$51,535.37 Age factor: Plus/minus \$1,145.63 for each year worker is under/over age 45 Maximum amount multiplied by percentage of impairment = \$74,439.52 Minimum amount multiplied by percentage of impairment = \$28,631.22  The benefit is paid as a lump sum if it is \$11,456.30 or less	\$51,535.37 \$1,145.63 \$74,439.52 \$28,631.22  \$11,456.30
48(2)	Lump sum to surviving spouse: Base amount = \$55,555.55 Age factor: Plus/minus \$1,388.88 for each year spouse is under/over age 40 Maximum lump sum = \$83,333.30 Minimum lump sum = \$27,777.76	\$56,952.77 \$1,423.81 \$85,429.13 \$28,476.37
48(4)	The minimum compensation amount payable for spouse and children = \$15,312.51/year	\$15,697.62
48(8)	If more than one person is entitled to receive periodic and lump sum payments as a spouse <ul style="list-style-type: none"> <li>• the total periodic payment does not exceed 85% of worker's NAE at the time of the injury, and</li> <li>• the total lump sum payment is limited to \$83,333.30</li> </ul>	\$85,429.13
48(13)	Aggregate lump sum payment for children when there is no surviving spouse = \$55,555.55	\$56,952.77
48(22)	Minimum burial or cremation expenses = \$2,083.32	\$2,135.72
54	Maximum earnings ceiling: 175% of the average industrial wage for Ontario for the year in which the accident takes place	\$59,200.00
<b>Pre-1998 Act</b>		
39(1)	The minimum temporary total disability benefit to a worker is <ul style="list-style-type: none"> <li>• \$10,500/year when the NAE are equal to or more than \$10,500, or</li> <li>• the actual NAE if earnings are less than \$10,500/year</li> </ul>	\$15,312.51
50(3)	Maximum clothing allowance: <ul style="list-style-type: none"> <li>• upper limb prosthesis = \$184</li> <li>• lower limb prosthesis/back brace/leg brace = \$368</li> </ul>	\$255.55 \$511.12
147(14)	Additional monthly payment of up to \$200 for workers in receipt of permanent partial disability benefits	\$202.20

# Faits et chiffres pour 1999

Tous les ans, les prestations sont indexées en fonction du facteur d'indexation approprié. Pour 1999,

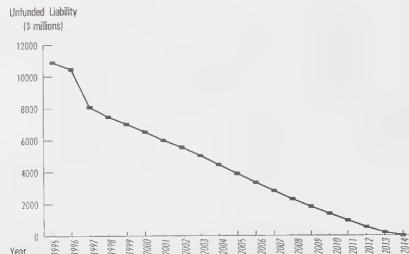
- le facteur d'indexation général (Friedland modifié) est de 0 %;
- le deuxième facteur d'indexation (Indice des prix à la consommation) est de 1 %.

Dans la première et la deuxième colonne, nous avons indiqué l'article de loi pertinent et le montant prévu par la *Loi*. Dans la troisième colonne, vous trouverez le montant indexé pour 1999. Les montants qui n'ont pas changé sont ceux qui ont été indexés en utilisant le facteur d'indexation général de 0 %. Pour plus de renseignements sur l'indexation, veuillez vous reporter au *Manuel des politiques opérationnelles*.

Article de la Loi	Montant prévu par la Loi	Montant pour 1999
43 (2)	Le montant annuel minimal accordé pour la perte de gains totale est le moins élevé des deux montants suivants : <ul style="list-style-type: none"> <li>• 15 321,51 \$, ou</li> <li>• les gains moyens nets du travailleur au moment de la lésion</li> </ul>	15 321,51 \$
45 (6)	Pension de retraite : La pension est versée sous forme de paiement forfaitaire si elle est inférieure à 1 142,20 \$ par année	1 142,20 \$
46	Indemnité pour perte non financière (PNF) : Montant de base = 51 535,37 \$ Facteur d'âge : plus/moins 1 145,63 \$ pour chaque année que le travailleur a de moins/de plus que 45 ans; Montant maximal multiplié par le pourcentage de déficience = 74 439,52 \$ Montant minimal multiplié par le pourcentage de déficience = 28 631,22 \$	51 535,37 \$ 1 145,63 \$ 74 439,52 \$ 28 631,22 \$
	L'indemnité pour PNF est versée sous forme de paiement forfaitaire si elle est de 11 456,30 \$ ou moins	11 456,30 \$
48 (2)	Paie forfaitaire versée au conjoint survivant : Montant de base = 55 555,55 \$ Facteur d'âge : plus/moins 1 388,88 \$ pour chaque année que le conjoint a de moins/de plus que 40 ans. Paie forfaitaire maximale = 83 333,30 \$ Paie forfaitaire minimale = 27 777,76 \$	56 952,77 \$ 1 423,81 \$ 85 429,13 \$ 28 476,37 \$
48 (4)	Montant minimal payable au conjoint et aux enfants = 15 312,51 \$ par année	15 697,62 \$
48 (8)	Si plus d'une personne a droit à des versements périodiques ou à des paiements forfaitaires à titre de conjoint <ul style="list-style-type: none"> <li>• les versements périodiques ne dépassent pas au total 85 % des gains moyens nets du travailleur au moment de la lésion, et</li> <li>• le paiement forfaitaire ne peut dépasser au total 83 333,30 \$</li> </ul>	85 429,13 \$
48 (13)	Paie forfaitaire totale versée aux enfants (aucun conjoint survivant) = 55 555,55 \$	56 952,77 \$
48 (22)	Frais d'inhumation ou d'incinération : Montant minimal = 2 083,32 \$	2 135,72 \$
54	Montant maximal des gains : 175 % du salaire moyen dans l'industrie en Ontario durant l'année où est survenue l'accident	59 200,00 \$
<b>Loi d'avant 1998</b>		
39 (1)	Montant minimal payable en cas d'invalidité totale temporaire correspond : <ul style="list-style-type: none"> <li>• à 10 500,00 \$ par année si les gains moyens nets au moment de la lésion sont de 10 500,00 \$ ou plus;</li> <li>• au montant des gains moyens nets réels au moment de la lésion si ceux-ci sont inférieurs à 10 500,00 \$ par année</li> </ul>	15 312,51 \$
50 (3)	Allocation vestimentaire maximale : <ul style="list-style-type: none"> <li>• prothèse à un membre supérieur = 184,00 \$</li> <li>• prothèse à un membre inférieur, appareil orthopédique pour le dos ou attelle à la jambe = 368,00 \$</li> </ul>	255,55 \$ 511,12 \$
147 (14)	Montant mensuel additionnel pouvant aller jusqu'à 200,00 \$ versé aux travailleurs qui reçoivent des prestations d'invalidité partielle permanente	202,20 \$



## Projection of the Unfunded Liability from 1995-2014



### Revenue policy information

For further information or for copies of the 1999 premium rates brochure, please contact the Revenue Policy Branch at (416) 344-4141, or toll-free 1-800-387-0750, Ext. 4141.

Accident  
Prevention

## Incentive Programs ... in 1999 and Beyond

For most employers\*, the Board provides shared-liability insurance. Rather than paying the costs of a claim dollar for dollar, employers are charged premiums based on the size of their payroll and the risks in their industry.

Overlaid on the premium rates, the Board runs four programs that financially reward accident prevention and return to work efforts. These programs give employers who have better than average accident rates a competitive advantage over those who do not perform as well in their industry. In this way, the programs encourage employers to improve workplace safety in Ontario.

Incentive programs are not entirely new to the Board, but they continue to evolve as the Board strives to

- reach more people with the accident prevention and health and safety message
- improve fairness in cost distribution among employers
- improve the WSIB's overall financial footing, and
- respond to employers' concerns about the complexity of programs.

The following is a brief description of the four incentive Programs, how they are changing in 1999, and a preview of what's to come.

\* Schedule 2 employers pay the full costs of their claims, plus an administrative fee.

### New Experimental Experience Rating (NEER)

The NEER program provides financial incentives to employers to reduce the costs associated with their accidents through

- improving accident prevention activities, and
- participating in the return to work of their workers.

It does this by linking premium refunds and surcharges to the costs of accidents. Employers with a better than average record compared with similar-sized firms in the same rate group get a refund, those with a poorer than average record pay a surcharge.

### Correcting the NEER "off-balance"

The "off-balance" is the difference between the total amount the Board pays out in refunds, and the amount it collects in surcharges under NEER in a given year. Over the past few years, the Board has been refunding considerably more money than it has collected in surcharges, between \$250 - \$350 million per year.

In 1997 the Board introduced a new rate-setting model that will reduce the off-balance significantly. The new model was first used to set the 1998 rates. Its impact on NEER refunds and surcharges will be seen in 1999, when 1998 accident performance is evaluated. The new model aims to more closely relate premium rates to current cost records, and to ensure that refunds reflect real safety improvements.

### CAD-7

CAD-7 is an accident prevention incentive program geared specifically to the construction industry. It ties workplace safety to premium refunds and surcharges by providing a method for adjusting premiums based on a combination of an employer's accident frequency and claims costs.

### Merit Adjusted Premium (MAP) Plan

The Board introduced MAP in 1998 in response to concerns expressed by small employers about the complexity of the NEER program. MAP is a simplified incentive program for the small business community.

Under MAP, the Board "individualizes" rate group premium rates by applying a percentage adjustment. The adjustment is based on the number of claims\*\* with costs over a specified threshold that an employer has in the three years before the year in which the adjustment is calculated. For the 1998 MAP adjustment, the threshold was \$300. For the 1999 adjustment, it is \$500.

For example, the Board will calculate the adjustments to be applied to small business employers' premium rates in 1999 using information on the number of approved claims, (i.e. with costs of \$500 or more) each small employer had in '95, '96, and '97.

Starting in 1999, the Board will also apply a 10% premium rate surcharge for each claim an employer has costing over \$5,000. The maximum premium rate surcharge an employer may be subject to under MAP is 50%.

By adjusting rates before employers pay their premiums for the year, the Board makes it possible for employers to realize savings sooner than is possible under NEER.

Employers who make annual premium payments between \$1,000 and \$25,000 are automatically assessed under the MAP program. It is not necessary to apply to participate. The program is not open to construction industry employers (see CAD-7).

### Safe Communities Incentive Program (SCIP)

As the name suggests, SCIP makes workplace safety a community concern. It does this by treating all the registered employers in a community as one large company. If the group as a whole generates lower claims costs than anticipated, the employers in the group share 75% of the savings. If the group does not improve on its claims costs, no surcharge is applied.

Participants also get

- access to a health and safety consulting team, training programs, and other resources
- assistance in improving their claims and return to work management, and
- an evaluation of their health and safety management system to improve their performance.

The Board has been running SCIP as a three-year pilot program since January 1997. So far it is generating tremendous results. In the program's first year, the Board returned \$664,049 to the 145 employers enrolled. These savings were in addition to any other rebates these employers qualified for through other Board incentive programs. In 1999, the Board will evaluate SCIP's success and decide if it is to continue.

To participate in SCIP, a business must

- be within a Safe Community, i.e., a community registered with the Safe Communities Foundation. For information on how to register contact the Foundation in Toronto at (416) 964-0008.
- be part of a community with a local steering committee and an action plan accepted by the Foundation
- be registered with the Board as a Schedule 1 employer
- pay up to \$90,000/year in Board premiums, and
- take part in safe workplace awareness training and agree to participate in an evaluation of its health and safety practices.

SCIP is up and running in the following communities: Ajax/Pickering, Belleville, Brockville, Kingston, Orillia, Owen Sound, Peterborough, Rainy River District, Sarnia-Lambton County, Smiths Falls, and Waterloo. Several others are joining SCIP in 1999.

### What's in the future?

Many Ontario employers can be proud of the reduction in claims costs we have witnessed over the last decade thanks to their efforts and the Board's accident prevention incentive programs.

The Board has started a broad-based review of NEER and CAD-7. This review will be accompanied by public consultation. Major changes to these programs are not expected to be implemented until 2001.

For more information on the incentive programs call (416) 344-1016, or toll-free 1-800-663-6639.

\*\* Long latency disease claims are not included in these counts.

## New Policy on Treatment after Exposure to HIV

The Board has a new policy on entitlement for workers who, as part of their job, become exposed to blood or body fluids that may carry the human immunodeficiency virus (HIV).

While the Board has paid health care and other benefits to workers exposed to HIV since 1986, it was under the authority of Directive 12C (Board Minute 4763 #11, November 17, 1978) which took into account exposure to any infectious disease.

The new Post-Exposure Prophylaxis (PEP) policy (Administrative Minute #1, August 11, 1998, page 233) looks exclusively at types of HIV exposures and suggested therapies that workers should receive.

The guidelines used by the Board to pay benefits mirrors those recently introduced by the Canadian Federal Laboratory Centre For Disease Control (LCDC). Based on research to date, the LCDC recommends that PEP therapy be a combination of at least two drugs, e.g., zidovudine and lamivudine, and possibly a third drug (such as indinavir), if necessary.

The greatest risk of infection occurs after puncture wounds with needles contaminated with blood or body fluid known to be infectious for HIV. Splashes into open wounds or mucuous membranes (e.g., eyes or mouth) also carry an elevated risk.

For a copy of the approved policy, please contact Policy Publications at (416) 344-4355, or toll-free 1-800-387-0750, Ext. 4355.

### Types of Exposure and Entitlement to PEP Therapy

Type of Exposure	Blood/Body Fluids	Entitlement to PEP Drug Therapy
any needlestick skin puncture or mucous membrane exposure in a lab or similar setting	concentrated virus	Yes
skin puncture	blood or other infectious body fluids (vagina/uterine, semen, and pleural, amniotic, pericardial, peritoneal, synovial or cerebrospinal fluid)	Yes
	non-blood urine, feces	No
mucuous membrane or open wound	blood and other infectious body fluids (see above)	Yes
	non-blood urine, feces	No

*The WSIB ... working toward the elimination of all workplace injuries and illnesses.*

## Independent Living Policies

(cont'd from page 1)

Requests for a guide dog or support animal can be made with the recommendation of a health care practitioner. Mobility training is done through an assistive animal training school or the Canadian National Institute for the Blind.

For a copy of the approved policies, please contact Policy Publications at (416) 344-4355, or toll-free at 1-800-387-0750, Ext. 4355.

## Training Agencies, Employers, and Unpaid Trainees Benefit from New Regulation

More training agencies now have the option of becoming the "employer" of unpaid trainees for workplace safety and insurance purposes, making it easier for them to recruit placement hosts (employers).

Training agencies, as well as private schools registered under the *Private Vocational Schools Act*, may become the employer for unpaid trainees during their work placement. Under Regulation 175 of the *Workplace Safety and Insurance Act*, training agencies include, but are not limited to

- educational institutions; and
- persons, partnerships, trade unions, and other organizations that arrange vocational training, or provide vocational services.

For more information, call Revenue Operations at (416) 344-1013 or toll-free 1-800-387-8638.

## Season's Greetings

May the warmth and joy of the season  
remain in your heart throughout the coming year.  
Wishing you a happy, healthy, and prosperous 1999.

from the Policy and  
Research Division

# POLICY REPORT

WSIB  
CSPAT

Workplace Safety &  
Insurance Board  
Commission de la sécurité  
professionnelle et de l'assurance  
contre les accidents du travail

Policy Report subscriptions are free.

Policy Report is published by the Benefits Policy Branch of the Workplace Safety and Insurance Board. If there is any conflict between information in this publication and the *Workplace Safety and Insurance Act* or approved policy documents, the Act or the policy governs.

In this publication, the "old Act" refers to the *Workers' Compensation Act*. The "new Act" refers to the *Workplace Safety and Insurance Act*.

Benefits Policy also publishes the *Operational Policy* manual, the *Employer Classification* manual, and a bilingual lexicon.

To purchase any of these publications, or to receive *Policy Report*, please call Policy Publications at (416) 344 - 4355, or 1-800 - 387-0750, Ext. 4355.

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# POLICY REPORT

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Workplace Safety &  
Insurance Board

Commission de la sécurité  
professionnelle et de l'assurance  
contre les accidents du travail

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## Self-reliance and early and safe return to work

*Getting an injured worker back to work is best accomplished by the people  
that know the workplace best—the worker and the employer.*

**S**elf-reliance is the principle that underlies the Board's new approach to post-injury return to work activities, or early and safe return to work (ESRTW). It's not as new as it seems, though. Well before Bill 99 moved the Board away from directly providing vocational rehabilitation, self-reliant employers managed their own return-to-work programs, as part of comprehensive occupational health and safety programs. The Board's role in these cases was essentially supportive: it became involved only if the employers' and workers' efforts failed. In effect, Bill 99 has made it a requirement that **all** workplaces practice self-reliance.

In support of this approach, the Board has implemented a number of ESRTW and related policies (see side-bar). Rather than describing each policy in turn, the following case study—admittedly an idealized and generalized one—shows how the ESRTW process could unfold. Listed below each step are some of the responsibilities or actions of the workplace parties (employer and worker), the treating health care professional, and the Board.

### ESRTW - A Case Study - Self-reliance in action

**Background** - CDP is a small employer with 15 employees that has been in business for 3 years. In that time there have been 4 work-related accidents, with none that resulted in more than 3 weeks of lost time from work. Because the company was late in reporting these accidents the Board has charged the company 4 times for late reporting.

The company is aware of Bill 99 and the Board's new approach to ESRTW, and realizes that the time has come for a comprehensive health and safety program that includes a strategy for preventing and dealing with work-related accidents.

### ESRTW & related policies

**The Goal of ESRTW and the Roles of the Parties** - outlines the roles of the workplace parties and the goal of ESRTW, and also deals with related issues, including workplace modifications, benefits, and travel expenses.

**Resources and Evaluations** - lists the types of resources that the decision-maker may suggest the workplace parties obtain.

**Mediation Services** - specifies how the Board mediates disputes between the workplace parties.

**Workers' Initial Accident-Reporting Obligations** - outlines a worker's responsibilities once a workplace injury has occurred.

**Employers' Initial Accident-Reporting Obligations** - explains the steps to be taken by an employer when a worker has a workplace injury.

# ESRTW—A Case Study

## Workplace committed to prevention, health, and safety

The owner and the general manager of the company endorse the idea of a comprehensive health and safety program, and devise a plan to create and implement one. They meet with the staff to get their input. The parties agree that

- everyone is responsible for health and safety
- supervisors and workers should have training in health and safety
- workers will select a health and safety representative\*
- health and safety performance should always be improved
- health and safety should be built into all jobs in the workplace to control hazards at their sources.

The plan is being developed when a test case comes up—a worker has an accident.

## The accident

Bridget lifts a 20 lb. box from under her workstation and twists to place it on her workbench. She feels an immediate, sharp pain in her lower back. The pain persists and makes it difficult for her to straighten up. She reports the accident to her supervisor, Dave.

Dave arranges for Bridget to be driven to the local hospital emergency department. While Bridget awaits the ride, Dave gets her accident history and starts completing the Employers' Report of Injury/Disease, Form 7. After Bridget signs the form, Dave gives her the worker's copy.

Dave also completes the background information on the Functional Abilities Form for Timely Return to Work (FA form), and explains its use to Bridget. Bridget takes the FA form to give to her doctor.

Bridget tells Dave that she will call him after the medical attention to advise him if the doctor recommends a layoff from work.

## Medical attention

The emergency doctor diagnoses a low back strain, orders X-rays, and prescribes muscle relaxants. Bridget is told not to return to work, and to see her family doctor for follow-up and further treatment if necessary. Bridget calls Dave to tell him of the doctor's recommendation.

The next day Bridget sees Dr. Myers, her family doctor, and gives her the FA form. Dr. Myers

- confirms the diagnosis
- recommends 4 to 6 weeks of physiotherapy
- authorizes a layoff for one week, and
- suggests returning to light work (e.g., work that does not involve any lifting) after the layoff.

Dr. Myers completes the Form 8 and the FA form, and mails them to the Board and the employer. The doctor gives Bridget her copy of the FA form directly.

## The employer

- provides a safe workplace
- provides a first aid station
- ensures that someone trained in first aid is on duty at all times, and
- permits Board staff access to the premises to ensure that the workplace is safe.

## The Board

- promotes prevention, workplace safety and ESRTW best practices
- motivates and supports workplaces to become self-reliant in health and safety
- through its partners, such as Safe Workplace Associations, supports incentive, training, and promotion programs, including
  - Certification Training
  - First Aid Program
  - Young Worker Awareness Program
  - Safe Communities Incentive Program.

For details about Prevention, call Corporate Communications at (416) 344-4200 or 1-800-387-0750, Ext. 4200, and ask for the brochure, *The WSIB & Prevention*.

## The employer

- provides immediate first aid
- records any first aid treatment or advice given to the worker
- if required, provides transportation to the doctor or hospital
- pays the worker full wages for the day of injury
- completes the Form 7 and sends it to the Board within 3 days of learning of an accident that causes a worker to
  - be absent from regular work
  - need modified work
  - earn less than regular pay at regular work, or
  - obtain health care
- gives the worker an FA form (see insert) to take to the treating health professional.

## The worker

- reports the accident to the employer
- signs the Form 7, thereby making a claim and consenting to the release of functional abilities information.

## The worker

- asks the treating health professional to complete the FA form
- co-operates and participates in medical rehabilitation.

## The treating health professional

- completes and submits to the Board the Physician's First Report, Form 8 (stocked by the health professional)
- completes and submits to the Board the FA form, and gives copies to the worker and the employer
- identifies the most appropriate treatment for the worker's injury
- ensures the worker receives timely access to treatment
- discusses the possibility of a return to work as soon as the worker is able.

\* A workplace with more than 5, but less than 20, workers is not required to have a Joint Health and Safety Committee. Instead, workers select a health and safety representative from their peers. For more information refer to s.8 of the Occupational Health and Safety Act and Regulations for Industrial Establishments (RSO, 1990).



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## **Clarification**

### ***Re: Appeals – time limits***

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Further to the article in this issue on appeals time limits, it should be clarified that the Board has special time limit provisions for objections to decisions that were made before January 1, 1998.

#### **Board decisions made before January 1, 1998**

Objections to decisions concerning early and safe return to work and labour market re-entry made before January 1, 1998 can be made up to January 31, 1998. Objections to all other Board decisions made before January 1, 1998 can be made up to June 30, 1998. Because there may be confusion over which pre-January 1998 decisions give rise to the 30-day time limit, the Board will be flexible in granting extensions to the appeal period in these cases.

#### **Board decisions made after January 1, 1998**

As explained in the Policy Report article, the time limits on objections to decisions made after January 1, 1998 extend for 30 days or 6 months (depending on the nature of the decision) from the date of the decision.

#### **Reconsiderations & time limit extensions**

The Board may reconsider any decision at any time, regardless of the decision date, if there are factual errors in the original decision, or if substantial new evidence becomes apparent.

Also, the Board may extend the appeals time limits where there are exceptional circumstances that made it impossible for the objecting party to appeal within the time limits.





# 1998 facts and figures

Each year, benefits are indexed by the appropriate indexing factor. For 1998

- the alternate indexing factor (Consumer Price Index or CPI) is 1.5%, and
- the general indexing factor (modified Friedland) is 0%.

In the first 2 columns, you will find the section of the Act and the legislated dollar amount. In the third, you will find the indexed amount for 1998. The amounts that have not changed are the ones that are indexed by the general indexing factor - 0%. For more information about indexing, please refer to the *Operational Policy* manual.

Section	Legislated dollar-amount	1998 \$ - Amount
43(2)	The minimum annual amount for full loss of earnings (LOE) is the lesser of <ul style="list-style-type: none"> <li>• \$15,321.51, or</li> <li>• the worker's net average earnings (NAE) before the injury</li> </ul>	\$15,321.51
45(6)	Retirement pension: Benefit paid as a lump sum if it is less than \$1,142.20/year	\$1,142.20
46	Non-economic loss (NEL) benefit: Base amount = \$51,535.37 Age factor: Plus/minus \$1,145.63 for each year worker is under/over age 45 Maximum amount multiplied by percentage of impairment = \$74,439.52 Minimum amount multiplied by percentage of impairment = \$28,631.22	\$51,535.37 \$1,145.63 \$74,439.52 \$28,631.22
	The benefit is paid as a lump sum if it is \$11,456.30 or less	\$11,456.30
48(2)	Lump sum to surviving spouse: Base amount = \$55,555.55 Age factor: Plus/minus \$1,388.88 for each year spouse is under/over age 40 Maximum lump sum = \$83,333.30 Minimum lump sum = \$27,777.76	\$56,388.88 \$1,409.71 \$84,583.30 \$28,194.43
48(4)	The minimum compensation amount payable for spouse and children = \$15,312.51/year	\$15,542.20
48(8)	If more than one person is entitled to receive periodic and lump sum payments as a spouse <ul style="list-style-type: none"> <li>• the total periodic payment does not exceed 85% of worker's NAE at the time of the injury, and</li> <li>• the total lump sum payment is limited to \$83,333.30</li> </ul>	\$84,583.30
48(13)	Aggregate lump sum payment for children when there is no surviving spouse = \$55,555.55	\$56,388.88
48(22)	Minimum burial or cremation expenses = \$2,083.32	\$2,114.57
54	Maximum earnings ceiling: 175% of the average industrial wage for Ontario for the year in which the accident takes place	\$58,200.00
Pre-1998 Act		
39(1)	The minimum temporary total disability benefit to a worker is <ul style="list-style-type: none"> <li>• \$10,500/year when the NAE are equal to or more than \$10,500, or</li> <li>• the actual NAE if earnings are less than \$10,500/year</li> </ul>	\$15,312.51
50(3)	Maximum clothing allowance: <ul style="list-style-type: none"> <li>• upper limb prosthesis = \$184</li> <li>• lower limb prosthesis/back brace/leg brace = \$368</li> </ul>	\$255.55 \$511.12
147(14)	Additional monthly payment of up to \$200 for workers in receipt of permanent partial disability benefits	\$202.20





# Functional Abilities Form

To receive workplace insurance benefits, a worker must apply for benefits within 6 months of the date of an accident or the onset of disease. When applying for benefits, the worker must also consent to the worker's health professional disclosing functional abilities information to the employer. Failure to file a claim or provide consent for the release of functional abilities information may result in the Board not providing benefits.

To help employers and workers arrange an early and safe return to work, the Board developed the Functional Abilities Form for Timely Return to Work, or FA form. The form is used to determine the worker's physical capabilities and limitations and to plan a return to work.

The form can only be completed by the health professional treating the worker. Diagnostic information is not included on the form and completing this form does not replace any of the health professional's other reporting obligations.

Illustrated below is a sample FA form. Employers may order these forms from the Board, or they may develop similar forms themselves. If the workplace parties use a form specific to their workplace, the employer also needs the separate consent of the worker. The Board pays the health professional, however, only if the information is submitted on the Board-developed form.

Employers, workers, and health professionals who have questions about this form may call 1-800-387-0750.

<b>WSIB</b> <b>CSP/PAI</b> Workplace Safety & Insurance Board Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail		200 Front Street West Toronto, ON M5V 3J1 200, rue Front Ouest Toronto, ON M5V 3J1		<b>Functional Abilities Form</b> <b>for Timely Return to Work</b>	
The following information should be completed by the employer or the injured worker. Please read the information on the reverse.					
Health No.		Claim No.		<input checked="" type="checkbox"/> Initial form <input type="checkbox"/> Follow-up form	
Date of Accident day month year 01 MAR 99		Employer Telephone No. Area Code Telephone (416) 344-0000		Worker's Last Name First Name KAPOOR BRIDGET	
Employer's Name CD PLAYERS		Full Address (No., Street, Apt.) 230 RODHAM ST		City/Town Province TORONTO ONT	
Full Address (No., Street, Apt.) 140 EASTGROVE LANE		City/Town Province Postal Code TORONTO ONT M4L-2C9		Postal Code Area Code Telephone No. M4L-3C9 ( )	
		Social Insurance No. 4651198 HXX		Date of Birth day month year 20 JAN 60	
Accident Information (This information should be completed by the employer or the injured worker.)					
Type of Job at Time of Injury		Area of Injury			
ASSEMBLER		LOW BACK			
The following information should be completed by the Health Professional:					
1 Date of examination on which the report is based		Area of Injury			
2 MARCH 99		LOW BACK			
2 Rehabilitation/Treatment Required?		Is the worker capable of returning to work immediately without restrictions?			
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Please complete where capabilities are known or limitations recommended. Note: "as tolerated" implies that restrictions are recommended but must be quantified in the workplace.					
<b>Capabilities</b> Walking: short distance only <input type="checkbox"/> ; as tolerated <input checked="" type="checkbox"/> ; other (eg. uneven ground) <input type="checkbox"/> Standing: less than 15 min <input type="checkbox"/> ; less than 30 min <input type="checkbox"/> ; as tolerated <input checked="" type="checkbox"/> ; other <input type="checkbox"/> Sitting: less than 30 min <input type="checkbox"/> ; less than 1 hour <input checked="" type="checkbox"/> ; as tolerated <input type="checkbox"/> ; other <input type="checkbox"/> Lifting floor to waist: less than 10 Kg <input type="checkbox"/> ; less than 25 Kg <input type="checkbox"/> ; as tolerated <input type="checkbox"/> ; other <input checked="" type="checkbox"/> NONE Lifting waist to shoulder: less than 10 Kg <input type="checkbox"/> ; less than 25 Kg <input type="checkbox"/> ; as tolerated <input type="checkbox"/> ; other <input checked="" type="checkbox"/> NONE Stair climbing: none <input type="checkbox"/> ; 2-3 steps only <input type="checkbox"/> ; short flight <input type="checkbox"/> ; own pace <input type="checkbox"/> ; as tolerated <input checked="" type="checkbox"/> Ladder climbing: none <input type="checkbox"/> ; 2-3 steps only <input type="checkbox"/> ; 4-6 steps only <input type="checkbox"/> ; own pace <input type="checkbox"/> ; as tolerated <input type="checkbox"/> NA					
<b>Limitations</b> <input checked="" type="checkbox"/> Bending or twisting of LOW BACK <input checked="" type="checkbox"/> Repetitive movement of LOW BACK <input type="checkbox"/> Chemical exposure to _____ <input type="checkbox"/> Environmental exposure to _____ <input type="checkbox"/> Operating motorized equipment <input type="checkbox"/> Restrictions related to medications: (specify) _____ <input type="checkbox"/> Above-shoulder activity <input type="checkbox"/> Below-shoulder activity _____ Exposure to vibration: high frequency <input type="checkbox"/> ; low frequency <input type="checkbox"/> Limit physical exertion to: mild <input type="checkbox"/> ; moderate <input type="checkbox"/> ; as tolerated <input checked="" type="checkbox"/>					
<b>General Comments/Specific Limitations</b>					
Recommendation for Work Hours <input type="checkbox"/> Full-time hours <input type="checkbox"/> Modified hours <input type="checkbox"/> Graduated hours <input type="checkbox"/> Complete Recovery Expected? <input type="checkbox"/> no <input checked="" type="checkbox"/> yes   Estimated Duration of Limitations   4-6 WEEKS					
Health Professional's Name (Please print)		Health Profession		Date of Next Appointment for Review of Capabilities	
DR. P. MYERS		G.P.		day month year 08 MAR 99	
Full Address		City/Town		Province	
1070 FLEET ST		TORONTO		ONT	
Date		Area Code		Telephone	
2 MAR 99		( )			
WSIB Agency Billing No.		Your own invoice No.		Service date	
				d d m m y y	
				Fee code	
				9 0 1	

The worker or the employer can complete the required background information.

The health professional completes the sections of the form detailing the worker's capabilities and limitations. If necessary an additional page may be attached to the form to provide more specific information.

# Formulaire sur la détermination des capacités fonctionnelles

**P**our recevoir des prestations d'accident du travail, le travailleur blessé doit présenter une demande de prestations dans les six mois qui suivent la date de l'accident ou de la maladie. Il doit également consentir à la divulgation des renseignements sur ses capacités fonctionnelles fournis par le professionnel de la santé traitant. Si le travailleur ne consent pas à la divulgation de ces renseignements ou ne présente pas une demande dans le délai prescrit, la Commission peut refuser de lui verser des prestations.

Pour aider les employeurs et les travailleurs à planifier un retour au travail rapide et sécuritaire, la Commission a créé le formulaire Détermination des capacités fonctionnelles pour un retour au travail rapide. Ce formulaire sert à déterminer les capacités ou limites physiques du travailleur et à planifier son retour au travail.

Seul le professionnel de la santé qui traite le travailleur peut remplir ce formulaire. Comme celui-ci ne sert pas à fournir des renseignements diagnostiques, le professionnel de la santé doit également s'acquitter de ses autres obligations de déclaration.

Un échantillon du formulaire sur les capacités fonctionnelles figure ci-dessous. Les employeurs peuvent se procurer ce formulaire auprès de la Commission ou préparer leur propre version. Si les parties du lieu de travail utilisent leur propre version, l'employeur doit aussi obtenir du travailleur un consentement distinct. Cependant, la Commission ne verse des honoraires qu'aux professionnels de la santé qui ont fourni les renseignements médicaux ou diagnostiques sur le formulaire qu'elle a créé.

Si vous avez des questions au sujet du formulaire, n'hésitez pas à composer le 1-800-387-0750.

<b>WSIB</b> <b>CSPAAT</b> Workplace Safety & Insurance Board <small>Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail</small> 200 Front Street West Toronto, ON M5V 3B1 200 rue Front Ouest Toronto (ON) M5V 3B1	<h2 style="margin: 0;">Détermination des capacités fonctionnelles pour un retour au travail rapide</h2> <p style="margin: 0;">Cette section doit être remplie par l'employeur ou le travailleur blessé. Veuillez lire les renseignements au verso.</p>
N° de carte santé _____ N° de dossier _____	<input checked="" type="checkbox"/> Premier formulaire <input type="checkbox"/> Formulaire de suivi
Date de l'accident : jour mois année <u>01 MAR 99</u>	N° de téléphone de l'employeur : ind régional <u>(416) 344-0000</u>
Nom de famille du travailleur : <u>KAPOOR</u> Prénom : <u>BRIDGET</u> Adresse au complet (n°, rue, app.) : <u>230 RUE RODHAM</u> Ville : <u>TORONTO</u> Province : <u>ONT</u> Code postal : <u>M4L-3C9</u> Ind. régional N° de téléphone : _____ N° d'assurance sociale : <u>465 198</u> Date de naissance : jour mois année <u>14 XO 20 JAN 1960</u>	
Nom de l'employeur : <u>CDP</u> Adresse au complet (n°, rue, app.) : <u>140 ALLÉE EASTGROVE</u> Ville : <u>TOR</u> Province : <u>ONT</u> Code postal : <u>M4L-2C9</u>	
<b>Renseignements sur l'accident</b> (Cette section doit être remplie par l'employeur ou le travailleur blessé.) Genre d'emploi au moment de l'accident (Si possible, joindre la description de tâches à ce formulaire.) : <u>ASSEMBLEUR</u> Siège de la lésion : <u>BAS DU DOS</u>	
<b>Cette section doit être remplie par le professionnel de la santé.</b> 1 Date de l'examen sur lequel le présent rapport est fondé? <u>2 MARS 1999</u> Siège de la lésion : <u>BAS DU DOS</u> 2 Readaptation ou traitements requis? <input checked="" type="checkbox"/> Oui <input type="checkbox"/> Non    Le travailleur peut-il retourner travailler immédiatement sans restrictions? <input type="checkbox"/> Oui <input checked="" type="checkbox"/> Non    Si non, veuillez remplir la section suivante. <b>Capacités</b> Marcher : sur de courtes distances seulement <input type="checkbox"/> ; tel que toléré <input checked="" type="checkbox"/> autre (p. ex. marcher sur un terrain accidenté) <input type="checkbox"/> Demeurer debout : moins de 15 min. <input type="checkbox"/> ; moins de 30 min. <input type="checkbox"/> ; tel que toléré <input checked="" type="checkbox"/> autre <input type="checkbox"/> Demeurer assis : moins de 30 min. <input type="checkbox"/> ; moins d'une heure <input checked="" type="checkbox"/> ; tel que toléré <input type="checkbox"/> ; autre <input type="checkbox"/> Soulever des charges : moins de 10 kg <input type="checkbox"/> ; moins de 25 kg <input type="checkbox"/> ; tel que toléré <input type="checkbox"/> ; autre <input checked="" type="checkbox"/> <u>AUCUN</u> Soulever des charges de la taille aux épaules : moins de 10 kg <input type="checkbox"/> ; moins de 25 kg <input type="checkbox"/> ; tel que toléré <input type="checkbox"/> ; autre <input checked="" type="checkbox"/> <u>AUCUN</u> Monter des : à éviter <input type="checkbox"/> ; 2 à 3 marches seulement <input type="checkbox"/> ; une courte volée d'escalier <input type="checkbox"/> ; à son rythme <input type="checkbox"/> ; tel que toléré <input checked="" type="checkbox"/> Grimper aux : à éviter <input type="checkbox"/> ; 2 à 3 échelons seulement <input type="checkbox"/> ; 4 à 6 échelons augmentant <input type="checkbox"/> ; à son rythme <input type="checkbox"/> ; tel que toléré <input type="checkbox"/> <u>SP.</u> 3 Capacité limitée de la main pour : tenir des objets <input type="checkbox"/> ; serrer des objets <input type="checkbox"/> ; dactylographier <input type="checkbox"/> ; écrire <input type="checkbox"/> <u>SO.</u> <b>Limitations</b> <input checked="" type="checkbox"/> Se pencher ou effectuer des mouvements de torsion au niveau de <u>BAS DU DOS</u> <input type="checkbox"/> Effectuer des mouvements répétitifs au niveau de <u>BAS DU DOS</u> <input type="checkbox"/> Exposition à des produits chimiques <input type="checkbox"/> Exposition environnementale à _____ <input type="checkbox"/> Utilisation d'équipement motorisé <input type="checkbox"/> Restrictions relatives à des médicaments (précisez) _____ <input type="checkbox"/> Activités effectuées au-dessus des épaules <input type="checkbox"/> Activités effectuées au dessous des épaules _____ Exposition à des vibrations : de hautes fréquences <input type="checkbox"/> ; de basses fréquences <input type="checkbox"/> Effort physique : léger <input type="checkbox"/> ; modéré <input type="checkbox"/> ; tel que toléré <input checked="" type="checkbox"/> 4 Recommandations portant sur les heures de travail : Heures de travail normales <input checked="" type="checkbox"/> modifiées <input type="checkbox"/> Heures de travail augmentées graduellement <input type="checkbox"/> 5 Prévoyez-vous un rétablissement complet? <input type="checkbox"/> Non <input checked="" type="checkbox"/> Oui    Durée estimative des limitations : <u>4 A 6 SEMAINES</u> Nom du professionnel de la santé (en caractères d'imprimerie) : <u>D P MYERS</u> Profession exercée : <u>GÉNÉRALISTE</u> Date du prochain rendez-vous pour réévaluer les capacités : jour mois année <u>08 MARS 1999</u> Adresse au complet : <u>1070 RUE FLEET</u> Ville : <u>TOR</u> Province : <u>ONT</u> Code postal : <u>M4L-4W4</u> Date : <u>2 MARS 1999</u> Ind. régional N° de téléphone : _____    Signature : <u>[Signature]</u> Numéro de facturation du fournisseur (CSPAAT) : _____    Votre numéro de facture : _____    Date du service : j m a d    Code des biens/droits : <u>901</u>	

Le travailleur ou l'employeur peut inscrire les renseignements de base requis.

Le professionnel de la santé doit remplir les sections du formulaire portant sur les **capacités et limites** du travailleur. On peut également joindre une page supplémentaire pour fournir des renseignements plus détaillés.



# Self-reliance in action

## Communication between the workplace parties

Bridget calls Dave after her appointment with Dr. Myers to tell him the doctor's recommendation. They discuss the possibility of suitable work. He thinks that he will be able to arrange light work in one or two weeks. They agree to keep in touch—Bridget to advise Dave of her recovery, and Dave to advise Bridget of the availability of suitable work.

Dave also mentions that he and the health and safety representative have worked out a way to deliver supplies to workstations that doesn't involve heavy lifting. This will prevent future accidents.



## ESRTW activities

Bridget starts her physiotherapy program and calls Dave to keep him informed. She also lets him know that the Board has approved her claim.

Dave receives the FA form and notes that Bridget cannot do any lifting. Dave calls the decision-maker at the Board for advice because the company does not, as yet, have an ESRTW plan. The decision-maker suggests that the employer arrange an ergonomic assessment of the workplace and that Bridget undergo a functional abilities evaluation (FAE).

The decision-maker, Dave, and Bridget agree to the ergonomic and the functional abilities assessments, and that a return to work date will be discussed based on the results.



## Worker returns to work

Bridget and Dave discuss the FAE findings and the ergonomic assessment. The FAE provides information regarding, for example, Bridget's limitations, while the ergonomic assessment gives suggestions to Dave on how to accommodate Bridget's lifting restriction.

Bridget and Dave agree on a suitable and available job that is within Bridget's functional abilities and at no wage loss.

Bridget returns to the identified job and continues with physiotherapy after work hours. Bridget contacts the decision-maker with her return-to-work date.

### The Board

- tells each party their obligations.

### The worker and employer

- contact each other as soon as possible after the injury, and maintain communication throughout the period of recovery or disability
- work together to identify a job consistent with the worker's functional abilities, that, if possible, restores the worker's pre-injury earnings
- give the Board any information the Board requests about the return to work activities
- notify the Board of any change in the worker's medical condition or change in the availability of suitable work
- notify the Board of any difficulties, obstacles, or disputes with each other throughout the ESRTW process.

### The Board

- contacts the worker and employer to determine whether any information is needed to help in the worker's early return to employment. The decision-maker may suggest that the workplace parties need
  - assistance in clarifying the worker's functional abilities
  - general ESRTW program development, and evaluation
  - information about sources of return-to-work assistance, agencies that conduct evaluations, workplace modifications, and assistive devices
- provides mediation services at the request of the workplace parties, or offers mediation services on its own initiative if difficulties and obstacles are identified through a review of the return to work activities
- ensures that the worker receives the appropriate loss of earnings benefits (LOE).

### The worker

- informs the Board of the expected and actual return to work date.

### The Board

- stops LOE benefits on the date the worker returns to work at no wage loss, or pays partial LOE benefits if the worker continues to experience a wage loss while at work
- measures the success of the workplace parties' ESRTW activities by considering whether
  - the worker returns to suitable work with the accident employer, and
  - the worker's pre-injury earnings are restored.

### ESRTW not successful

What happens if the ESRTW process is not successful—if, for instance, despite the best efforts of the workplace parties the worker is not successful in returning to work? Or, what if the worker returns to work but the suitable and available job pays significantly less than the pre-injury wage? If so, the Board may consider conducting a labour market re-entry (LMR) assessment to determine if the worker requires an LMR plan to enable a return to the workforce.

LMR will be explained in the next issue of *Policy Report*.

## New & Restored WSIB Firefighter Policies

Two policies will have a positive impact on the handling of firefighter claims in Ontario.

One is a new occupational disease policy which recognizes that firefighters with on-call fire smoke exposure have an increased risk of developing brain cancer or lymphoid leukemia.

The second policy is a result of Bill 92, which corrects an oversight in the Act by restoring

- the method of calculating volunteer firefighters and ambulance worker's average earnings, and
- their rights to re-employment and early and safe return to work (ESRTW) with their regular employer.

Should ESRTW be unsuccessful, these workers would be entitled to labour market re-entry services.

### New: occupational disease policy for urban firefighters

Studies show that full-time, urban firefighters have an elevated risk of developing

- brain cancer after 20 or more years of occupational exposure, and
  - lymphoid leukemia after 30 or more years,
- and that these diseases are likely caused by their employment.

Also the Board will adjudicate the claims of firefighters who have sustained other cancers, taking into consideration the intensity, type, and duration of occupational exposures, and the presence of non-occupational causes for the disease in each case.

This policy does not apply to forest/wildland or part-time firefighters.

### Restored: pre-1998 policy approach for determining volunteer firefighter benefits

Bill 92 restores the way 850 Schedule 1 employers and 130 Schedule 2 municipalities select the amount of coverage for their volunteer fire and ambulance workers. This means that retroactive to January 1, 1998,

- all workers of volunteer fire and ambulance brigades are covered at the amount selected by the employer/municipality, and premiums are based on this amount
- Schedule 1 municipalities do not have to report to Board the actual employment earnings of their volunteer fire and ambulance brigade workers
- the volunteer's actual (regular) employer is responsible for
  - maintaining employment benefits under section 25 of the Act
  - offering re-employment to an injured volunteer, and
  - participating in return to work activities.

For copies of the approved firefighter policies, please contact Policy Publications at (416) 344-4355, or toll-free at 1-800-387-0750, Ext. 4355.

### St. Catharines Office Re-Located

The St. Catharines office of the Workplace Safety and Insurance Board has moved to

301 St. Paul Street  
8th Floor  
St. Catharines ON  
L2R 7R4

The office's general enquiry telephone and fax numbers stay the same. They are

General enquiry line (local)	(905) 687-8622
General enquiry line (toll-free)	1-800-263-2484
Fax number	(905) 687-7117

# POLICY REPORT

**WSIB**  
ONTARIO  
**CSPAAT**

Workplace Safety &  
Insurance Board

Commission de la sécurité  
professionnelle et de l'assurance  
contre les accidents du travail

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# POLICY REPORT

Vol. 12, No. 2 October 1999



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"Clothing Allowance" and  
"Recovery of Benefit-related Debt"  
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## New OPM replaces Bill 99 policy book

Policy Publications is pleased to announce the availability of the new Workplace Safety and Insurance Board *Operational Policy* manual (OPM).

The policies contained in the new OPM reflect the WSIB's reinforced commitment to accident prevention and the key role played in this commitment by partnerships between employers, workers, and the WSIB. The policies also address the basic insurance principles involved in employer coverage and worker entitlement under the Act.

The new policies replace all of those in the *Bill 99 Operational Policies* book (published in January, 1998), **except:**

- Employers' Initial Accident-Reporting Obligations (3.1)
- Decision Making (3.7)
- Optional Insurance (14.1)
- Who Can Obtain Optional Insurance? (14.2)
- Individuals with Optional Insurance (4.3)
- Obligations on Purchase or Sale of Business (14.3), and
- Security for Payments (14.4).

These policies are still under review.

Most of the policies in this new OPM apply to either *decisions made* or *accidents occurring* on or after January 1, 1998. However, the policies on average earnings (18-02-02 to 18-02-06) apply to accidents occurring on or after October 1, 1999. Although the old, pre-Bill 99 OPM contains policies with application dates earlier than January 1,

1998, **many of these policies are still in effect.** For example, some revenue-related policies in the old manual are still relevant, and those concerning temporary total disability benefits continue to apply to accidents that occurred before January 1, 1998.

**If you own an old OPM, do not discard it.**

Ultimately, all revenue policies will be migrated to the new manual and deleted from the old one as they are updated or changed. As well, **all** policies that apply to

- post-January 1, 1998 claims, or
- both pre- and post-January 1, 1998 claims

will be migrated from the old OPM to the new OPM. Once this process is complete, the old manual will contain policies that apply **only** to pre-January 1, 1998 claims.

In this issue of *Policy Report*, we'll outline the changes made to WSIB operational policies that were previously published in the *Bill 99 Operational Policies* book, and you'll also find descriptions of some new policies.

If you would like to purchase a copy of the new OPM, call Policy Publications at 416-344-4355, or 1-800-387-0750, ext. 4355.

### Material Change in Circumstances – Employer (11-01-05)

- defines **material change in circumstances** and provides examples of changes in circumstances that must be reported by employers within 10 days of the material change
- outlines the WSIB's policy to take all necessary action against employers who intentionally fail to report a material change in circumstances

### Volunteer Forces (12-04-02)

- applies to all revenue and claims decisions made on or after January 1, 1998, regardless of the accident date
- includes Ministry of Solicitor General as a deemed employer
- changes method of establishing earnings for volunteer forces: deemed employer (usually a municipality) selects the same amount of earnings for each volunteer, and the volunteer's average earnings for the purpose of calculating benefits are now set at that selected amount
- adds obligation to co-operate (s.40), to re-employ (s.41), and to maintain employment benefits by the regular employer of the volunteer (cost to regular employer of meeting these obligations is reimbursed by deemed employer)

### Emergency Workers (12-04-03)

- applies to all revenue and claims decisions made on or after January 1, 1998, regardless of the accident date
- limits summoning authority for fighting fires to Ministry of Natural Resources and designates
- states that regular employer may deduct insurable earnings while emergency worker is covered under this policy
- adds obligation to co-operate (s.40), obligation to re-employ (s.41), and obligation to maintain employment benefits by the regular employer of the emergency worker, and states that the cost to the regular employer of meeting these obligations is reimbursed by the deemed employer

### Coverage for Ontario Works Participants (12-04-06)

- details coverage and earnings policy for individuals placed with employers as part of the Ontario Works program

### Foreign Agricultural Workers (12-04-08)

- applies to all revenue-related decisions made, and all claims for benefits filed, on or after January 1, 1998
- removes separate coverage provisions for foreign agricultural students

### Registration (14-02-02)

- requires new employers whose operations are compulsorily covered under the Act to:
  - contact the WSIB and provide information about their business operations within 10 days of hiring the first worker, and
  - provide a completed registration form to the WSIB by the end of the month following the month in which the first worker began employment
- establishes non-compliance and prosecution guidelines for employers failing to meet these requirements

### Closures (14-02-05)

- includes closure guidelines for Schedule 1 and Schedule 2 employer accounts
- addresses Schedule 1 closures for:
  - an entire business
  - one account when the employer has two or more accounts
  - a classification unit (CU)
  - a business activity

### Writs of Seizure and Sale (14-04-03)

- requires the filing of a Section 139 Certificate as the prerequisite of filing a writ of seizure and sale in order to establish a first lien

### Collections Based on Financial Hardship (14-04-04)

- clarifies the fact that phased payment plans are limited to Schedule 1 employers
- states that the WSIB may now realize any security provided by an employer defaulting on a plan



## Worker's Requirement to Claim and Consent (15-01-03)

NEW TITLE!

- changes title from "Workers' Initial Accident Reporting Obligations"
- reflects development and application of the Worker Claim/Consent Form, Form 1492
- extends, in certain circumstances, a worker's deadline for filing a claim from 14 calendar days to 30 calendar days
- adds additional guidelines to clarify the time limits in a case where an accident is not reported by the employer, there is a change in claim status, or exceptional circumstances exist

## Survivor's Requirement to Claim for Benefits (15-01-04)

NEW TITLE!

- changes title from "Survivors' Initial Accident Reporting Obligations"
- extends, in certain circumstances, survivor's deadline for filing a claim from 14 calendar days to 30 calendar days

## Wages and Employment Benefits for Day of Injury (15-01-08)

- confirms that, for purposes of this policy, overtime scheduled for the day of injury is considered wages

## Entitlement in Ontario and Other Jurisdictions (15-01-09)

- returns guidelines for coverage outside Ontario to old OPM document 02-03-07

## Pre-1990 Pension Supplements (18-01-03)

- removes references to vocational rehabilitation (VR) and details the new labour market re-entry (LMR) process
- states that s. 147(4) supplement can be adjusted at any time—even after final review—but only in cases when a change to the permanent impairment benefit results in a worker receiving more than 75% of gross pre-injury earnings, or 90% of pre-injury net average earnings (NAE)
- disallows LMR assessments for workers who are unemployed for reasons not related to work injury

## Determining Short-term Average Earnings (18-02-02)

NEW!

*Note: "Determining a Worker's Average Earnings" (4.1) in the Bill 99 Operational Policies book was revised and divided into 5 separate policies based on employment and earnings patterns.*

- defines **voluntary overtime** (extra work that a worker has the option of refusing) and **mandatory overtime** (extra work that a worker must perform)
- when determining short-term average earnings, now calculates voluntary overtime by averaging the amount worked in each of the 4 weeks prior to the injury, rather than determining the lowest amount common to each of the 4 weeks
- calculates mandatory overtime by averaging the amount worked in the 4 weeks before injury
- includes mandatory overtime in short-term average earnings, regardless of whether or not it is worked in each of the 4 weeks

## Determining Long-term Average Earnings –

Workers in Permanent Regular Employment (18-02-03)

Workers in Non-permanent or Irregular Employment (18-02-04)

- clarifies definitions of **permanent regular employment** and **irregular employment**
- considers as *irregularly* employed a worker who is permanently employed but, because of irregular hours or payment method, has earnings that vary from day to day or week to week
- sets the long-term average earnings recalculation period for all workers in irregular employment—including permanent workers who are irregularly employed (e.g. commissioned salespeople)—at 24 months

## Payment of LOE Benefits (18-03-02)

- adjusts loss of earnings (LOE) benefits for a worker receiving earnings from an employer (whether the worker is involved in ESRTW or LMR activities) based on 85% of the difference between the pre-injury NAE and the current NAE
- adds section permitting payment of LOE benefits if other benefits are already being paid (e.g. PD pensions, FEL benefits, and other LOE benefits)

## Reviewing LOE Benefits (18-03-03)

- replaces 5% material change threshold with a significance test that suggests significant material change is usually 5% or greater, but gives decision-makers more discretion in determining it
- allows decision-makers to consider, when deciding whether or not to conduct a review, the degree of impairment, whether the worker has returned to work, whether the worker is working in the SEB identified in the LMR assessment, and the amount of loss of earnings
- adjusts LOE benefit based on changes to wages identified in the worker's SEB (when worker has not returned to work or is not working in a job identified by the SEB and LOE benefit is based on wage guide information)
- when conducting final LOE review in the same circumstance, adjusts LOE benefit based on the most up to date wage guide information and the amount a fully experienced worker would earn in the SEB

## Commutations (18-03-05)

- combines election process for workers aged 55 or older, allowing them to elect the *no review* option and to request a commutation of 10% or smaller LOE benefit at the same time

## Eligibility for the Retirement Benefit (18-03-06)

- outlines eligibility for loss of retirement benefit for LOE recipients

## Electing the OAS Equivalent (18-04-09)

- states worker can elect to receive the Old Age Security (OAS) equivalent, or actual FEL benefit, any time a FEL or NEL review is conducted, provided criteria for OAS equivalent are met

## FEL Sustainability Benefit (18-04-13)

- defines **no wage loss**, and confirms that entitlement to sustainability benefit can be determined when the FEL benefit is first paid or at any review

## Reviewing FEL Benefits (18-04-14)

- replaces 5% material change threshold with a significance test that suggests significant material change is usually 5% or greater, but gives decision-makers more discretion in determining it
- clarifies policy regarding material change and workers receiving FEL before January 1, 1998: material change may alter FEL benefit from date it is reviewed *only* after January 1, 1998
- allows decision-makers to consider, when deciding whether or not to conduct a review, the degree of impairment, whether the worker has returned to work, whether the worker is working in the SEB identified in the LMR assessment, and the amount of loss of earnings
- changes date of final review to 55 months post-initial determination
- adjusts LOE benefit based on changes to wages identified in the worker's SEB (when worker has not returned to work or is not working in a job identified by the SEB and LOE benefit is based on wage guide information)
- when conducting final LOE review in the same circumstance, adjusts LOE benefit based on the most up-to-date wage guide information and the amount that a fully experienced worker would earn in the SEB
- clarifies when the FEL benefit ends: when worker has fully recovered, if there is no permanent impairment, or when worker turns 65

## Assessing Permanent Impairment (18-05-03)

- clarifies assessment procedure: if a second NEL assessment is conducted, either assessment, and/or the medical information in the file, can be used to make a permanent impairment decision

## Wage Loss for NEL Assessment (18-05-10)

- slightly revises wording in the chart that calculates the amount payable

## Early and Safe Return to Work – Overview (19-02-01)

- adds reference to small business, and states that WSIB may assist the workplace parties in achieving a successful ESRTW by arranging and paying for LMR services

## The Goal of ESRTW & the Roles of the Parties (19-02-02)

NEW TITLE!

- changes title from "ESRTW by Workplace Parties" to better reflect the document's content
- removes *appropriate employment* and replaces with *suitable and available employment*
- redefines *available employment*, and includes geographic guidelines to assist decision-makers in identifying comparable worksite
- includes additional guidelines for workers with Optional Insurance

## Functional Abilities Form for Timely Return to Work (19-02-04)

- addresses how the Functional Abilities form is used by workplace parties

## Labour Market Re-entry (LMR) Assessments (19-03-02)

- adds additional guidelines for dealing with lay-offs, strikes, and other actions unrelated to the work-related injury, and how these may affect the provision of an LMR assessment

## LMR Re-assessments (19-03-08)

- clarifies situations where workers return to an extensively accommodated job with the accident employer, or to a SEB through an LMR program, and that accommodated job or SEB later becomes unavailable

## Compliance with the Re-employment Obligation (19-04-03)

- removes one-week grace period for employers in non-compliance
- states that workers and employers have 30 days to file appeals of re-employment decisions

## Suitable Employment (19-04-06)

- clarifies ongoing nature of obligation to offer suitable employment

## Termination after Re-employment - Post 1998 (19-04-08)

NEW TITLE!

- changes title from "Termination after Re-employment"
- clarifies that the test used to rebut the presumption that termination was unrelated to injury applies only to terminations occurring *after January 1, 1998* (if the termination occurred *before January 1, 1998*, old OPM document 07-05-11 applies)

## Re-employment Penalties and Payments (19-04-09)

- clarifies types of benefits and services that can be offered to a worker whose employer has breached the re-employment obligation: depending on circumstances, some workers are offered LMR services, some are offered services in a return to work placement program

## LMR - Assessments for Surviving Spouses (20-02-03) Plans for Surviving Spouses (20-02-04)

- address specific needs of surviving spouses

## Transitional Provisions for Vocational Rehabilitation - Surviving Spouses (20-02-05)

- with 20-02-03 and 20-02-04, enables ESRTW for surviving spouses

## Separated Spouses (20-03-08)

- changes entitlement to confirm that if a court order exists, a spouse must be named in the order to be eligible as a separated spouse
- states that if there is no court order, a spouse can establish entitlement as a separated spouse by showing evidence of financial dependency (EFD)

## Apportionment of Survivors' Benefits for Spouses (20-03-09)

- changes wording to indicate that, in cases where there is a current spouse and a separated spouse, no apportionment is required if the spouses' combined entitlement does not exceed 85% of the worker's NAE

# A closer look...

Since the last issue of *Policy Report*, several new policies have been implemented. Here's a more detailed look at 2 of them.

## Clothing allowance

### Why the change?

Concerns arose among injured workers who had been wearing back braces for many years and were told by the WSIB that their braces were no longer required.

### Application date

The new policy applies to all decisions made on or after July 1, 1999. Allowances restored under special circumstances are payable as of the worker's 1999 NEL/PD anniversary, and covering only the previous 12 months.

### Policy changes

- The policy no longer dictates which health care professional should submit the medical report that must accompany an application for a clothing allowance.
- Clothing allowances may be made for workers who
  - do not meet the entitlement criteria
  - began using an assistive device or prosthesis before November 1, 1996, and
  - continue to be dependent on the assistive device or prosthesis.

## Recovery of benefit-related debts

### Why the change?

The previous policy did not differentiate between recoverable and unrecoverable debts. The new policy strikes a balance between debts that the WSIB should or could reasonably pursue, and debts that should be forgiven.

### Application date

The new policy applies to all benefit-related debts created on or after May 1, 1998.

### Policy changes

Debt recovery *will* be pursued when there is

- duplication of employment earnings and benefits
- failure to report material change
- fraud and/or misrepresentation, or
- an administrative error of which the debtor was aware or reasonably should have been aware.

Debt recovery *will not* be pursued when:

- the debt results from a decision that was overturned on reconsideration or appeal\*
- the debt is due to an administrative error of which the debtor could not reasonably have been aware
- the debtor was not notified of the debt within 3 years of its becoming due and owing,\* or
- recovery would result in severe, long-term financial hardship for the debtor.

\*These limitations do not apply in cases of fraud, misrepresentation, or failure to report material change

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## New policy clarifies accident-reporting

### "Employers' Initial Accident-reporting Obligations" approved

Following an extensive review, the WSIB has revised its accident-reporting policy.

Making the changes wasn't an easy process. If the new policy, for example, were to result in the under-reporting of work-related accidents, the health and safety of Ontario's workers could be jeopardized. On the other hand, if employers began to report every accident, the WSIB would risk becoming bogged down in paperwork and being unable to help workers and employers.

After much careful deliberation, however, a policy was created that strikes a balance between worker rights and administrative efficiency. The new policy, "Employers' Initial Accident-reporting Obligations" (OPM 15-01-02), applies to accidents occurring on or after March 1, 2000.

#### New definitions

Chief among the changes is the distinction, made for the first time, between first aid and health care.

*First aid* is a one-time treatment given to a worker. It can include:

- the cleaning of minor cuts, scrapes, or scratches
- the treatment of minor burns
- the application of bandages, dressings, splints, etc., and
- any follow-up visit made for *observation purposes only*.

*Health care*, on the other hand, includes

- services requiring the professional skills of a health care practitioner
- services provided by or at hospitals or health facilities
- prescription drugs.

The new definitions make it easier to decide when to report.

An employer should not report an accident if

- the worker was treated by a co-worker or a manager, or
- the worker was treated by a health care practitioner, but was given *only* first aid,

because, simply, there is no point in reporting an accident after which no time is lost or no health care is given.

An employer *must* report if the worker received health care, regardless of whether the treating practitioner works for the employer or the worker is treated at work.

#### Exposure to infectious diseases

The policy establishes special guidelines for cases where a worker is exposed to an infectious disease.

In cases of accidental exposure, there is no need to report if a health-care practitioner *only* tests and monitors the worker for the presence of an infectious disease, *provided the employer maintains accurate records of the incident and any subsequent testing and monitoring*. Blood-borne infectious diseases often stay latent for long periods of time, if they develop at all, so the WSIB does not require reporting until the worker tests positive, or until some type of treatment is administered.

#### Modified work

There are also new rules for modified work: Under the new policy, an employer does not have to report an accident if the worker performs modified duty at regular pay for seven calendar days, or less, following the date of the accident (provided the worker doesn't require health care).

(cont'd p.4)

# Revenue policies approved

Since the last issue of *Policy Report*, several new revenue policies have been approved. Here's a closer look at three of them...

## Optional insurance (12-03-02)

The new policy changes how the WSIB cancels coverage, calculates average earnings for premium and benefit purposes, and deducts overdue premiums from benefit payments.

### Cancellation of coverage

The WSIB now has the right to cancel optional insurance coverage for employees of corporations that have unpaid premiums. If a sole proprietor, partner, or independent operator has unpaid optional insurance premiums, the WSIB can cancel coverage with 15 days' notice.

### Calculation of average earnings

When determining premiums, the WSIB sets average earnings according to the optional insurance holder's actual earnings:

- in business *less* than one year — average earnings are set at one-third of the maximum earnings
- in business *more* than one year — average earnings are based on the holder's current tax return or audited financial statement, using the net business income as a base and adding back such deductions as pension and RRSP contributions, depreciation and amortization, dividends and expenses.

Average earnings for executive officers are set based on a current tax return or, if they have been employed less than a year, their stated salary.

When determining benefits, the WSIB uses either the approved amount of optional insurance, or the amount calculated from the holder's tax return or financial statement, whichever is less.

### Deduction of premiums from benefits

If an optional insurance holder is entitled to benefits but has premiums overdue, the WSIB may deduct the money owed from loss of earnings (LOE) benefits.

## Security for payment (14-04-02)

The new policy allows the WSIB to require an employer to provide *security for payment* of premiums which are due, or may come due, on the employer's account. Within 15 days of

being asked to do so, an employer must provide security to cover as much as one year of premiums.

Security for payment could be:

- a cash deposit toward future premiums
- a Letter of Credit from a financial institution
- an interest in real or personal property provided by way of a mortgage or a security agreement
- a personal guarantee from the owner or an executive officer of a corporation.

The WSIB may require security if an employer:

- has overdue premiums
- has a history of not paying premiums
- is carrying on business in Ontario on a temporary basis (less than 12 months)
- has its headquarters outside Ontario
- has shown signs of financial hardship, and has caused doubt about its ability to meet its financial obligations to the WSIB
- is in receivership or under the direction of a manager or a trustee.

The WSIB will call in security when an employer defaults on its payments, or when the employer fails to comply with the terms of a payment arrangement it made with the WSIB.

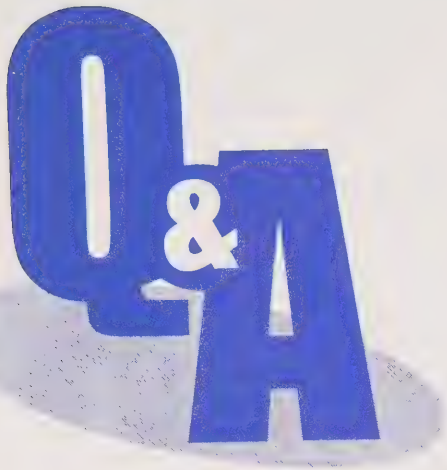
## Purchase certificates (14-02-03)

Successor employers who acquire part or all of a business are liable for the previous owner's unpaid premiums. To protect themselves from this liability, successor employers should request a *purchase certificate* from the WSIB. Valid for 30 days, a purchase certificate verifies that the previous employer has paid all its premiums.

This policy does not apply to trustees in bankruptcy, receivers, or liquidators who obtain property in that capacity.

For more information on these new Revenue policies, call the WSIB's Revenue Policy Branch at (416) 344-4141, or 1-800-387-0750, ext. 4141, and ask to speak to the Revenue Policy Analyst On-Call.





# LOE & FEL Reviews

## **1. Final review — determining earnings**

Edwin just completed a labour market re-entry (LMR) plan, and his earnings were deemed to be the entry-level wages in the suitable employment or business (SEB) that was identified for him. Edwin's 60-month review (R2) is to take place in two months.

**If Edwin returns to the workforce in the identified SEB before the final review, will his FEL benefit be based on actual or deemed earnings? If it is based on the deemed earnings, can those earnings be adjusted to reflect those of an experienced worker, given that in two months Edwin's FEL will be locked in until age 65?**

In accordance with the LMR model, Edwin's deemed earnings are used for paying the FEL benefit when the LMR plan is complete. The deemed earnings are based on the most up-to-date wage guide information for the SEB that was identified for him. Once Edwin finds employment, his actual earnings will be compared with the deemed earnings. If his actual earnings are higher than the deemed earnings, the actual earnings will be used in calculating the FEL, since they represent Edwin's true future economic loss. However, if his actual earnings are lower than the deemed earnings, the deemed earnings will be used to pay the FEL.

Since the final FEL review occurs so soon after the completion of the LMR plan, the deemed earnings would not be adjusted to reflect those of an experienced worker — Edwin won't have been in the position long enough at R2. Even if there is a chance he'll achieve those earnings in two to five years, policy does not support the projection of earnings at final review if the worker is employed in the identified SEB. Further, since his deemed earnings were based on wage guide information that will not likely change in two months (at R2), they will not be updated at the final review.

## **2. Part-time work in identified SEB**

Louise begins working in the SEB that was identified for her, but decides to work only part-time.

**For purposes of reviewing the LOE benefit, is Louise employed in the identified SEB?**

If Louise was working full-time before the injury, the SEB identified for her is likely to be full-time as well (unless otherwise indicated). As a result, Louise can only be considered in the "SEB-identified job" if she is working full-time. In fact, based on the LMR model, Louise's earnings would be deemed based on the full-time job, so the LOE benefit would be paid on the deemed earnings, and would not be adjusted if the worker began working part-time.

## **3. Earning entry-level wages at final review**

Thomas had his final FEL review (R2) in February 1998. His FEL benefit was based on updated earnings for his identified SEB as though he were a fully experienced worker, since he had not returned to work. He remained unemployed until December 1999, when a suitable job became available. Thomas now no longer has a wage loss.

**Can Thomas' adjudicator terminate his FEL benefit as of December 1999?**

No. After a final FEL review, the benefit is locked in until the worker turns 65. Any material change that could affect Thomas' FEL benefit, such as an increase in earnings, a return to work, or a full recovery from the injury, cannot be considered. Only if, before the final review, a material change went unreported, there was misrepresentation, or the worker committed fraud, could the WSIB review the FEL benefit after R2.

# Facts and figures 2000

Each year, benefits are indexed by the appropriate indexing factor. For 2000

- the general indexing factor (modified Friedland) is 0.2%, and
- the alternate indexing factor (Consumer Price Index or CPI) is 2.3%.

In the first two columns, you will find the section of the *Act* and the legislated dollar amount under that section. In the third, you will find the indexed amount for 2000. For more information about indexing, please refer to 18-01-02, Benefit Dollar Amounts, in the *Operational Policy Manual*.

43(2)	The minimum annual amount for full loss of earnings (LOE) is the lesser of • \$15,321.51, or • the worker's net average earnings (NAE) before the injury	\$15,352.15
45(6)	Retirement pension: Benefit paid as a lump sum if it is less than \$1,142.20/year	\$1,144.48
46	Non-economic Loss (NEL) benefit: Base amount = \$51,535.37 Age factor: Plus/minus \$1,145.63 for each year worker is under/over age 45 Maximum amount multiplied by percentage of impairment = \$74,439.52 Minimum amount multiplied by percentage of impairment = \$28,631.22  The benefit is paid as a lump sum if it is \$11,456.30 or less	\$51,638.44 \$1,147.92 \$74,588.40 \$28,688.48  \$11,479.21
48(2)	Lump sum to surviving spouse: Base amount = \$55,555.55 Age factor: Plus/minus \$1,388.88 for each year spouse is under/over age 40 Maximum lump sum = \$83,333.30 Minimum lump sum = \$27,777.76	\$58,262.67 \$1,456.54 \$87,393.99 \$29,131.32
48(4)	The minimum compensation amount payable for spouse and children = \$15,312.51/year	\$16,541.26
48(8)	If more than one person is entitled to receive periodic and lump sum payments as a spouse • the total periodic payment does not exceed 85% of worker's NAE at the time of the injury, and • the total lump sum payment is limited to \$83,333.30	\$87,393.99
48(13)	Aggregate lump sum payment for children when there is no surviving spouse = \$55,555.55	\$58,262.67
48(22)	Minimum burial or cremation expenses = \$2,083.32	\$2,184.83
54	Maximum earnings ceiling: 175% of the average industrial wage for Ontario for the year in which the accident takes place	\$59,300.00
<b>Pre-1998 Act</b>		
39(1)	The minimum temporary total disability benefit to a worker is • \$10,500/year when the NAE are equal to or more than \$10,500, or • the actual NAE if earnings are less than \$10,500/year	\$15,343.13
50(3)	Maximum clothing allowance: • upper limb prosthesis = \$184 • lower limb prosthesis/back brace/leg brace = \$368	\$255.56 \$511.12
147(14)	Additional monthly payment of up to \$200 for workers in receipt of permanent partial disability benefits	\$208.70



# Y2K research grants

Recently, the WSIB's Research Advisory Council (RAC) issued a request for proposals (RFP) for the year 2000 entitled "Solutions for Workplace Change". Intended to provide new information to help prevent work-related injuries, to improve the return-to-work process for injured workers, and to help ensure the fairness of employer assessment and worker compensation, the RFP asked researchers to explore:

- workplace safety for young workers
- the work-relatedness of diseases such as cancers
- the effectiveness of programs intended to reduce work-related injury and illness
- the special health and safety problems confronted by small businesses, and other such issues.

If you're unfamiliar with the RAC, here's a brief history: in 1998, the WSIB formed the RAC, bringing together stakeholders from the employer and worker community and representatives from the research community, Ontario's health and safety agencies, the Ministry of Labour and the WSIB. Since then, the Council has been chiefly concerned with providing grants for research into occupational health and safety, and advising the WSIB's Board of Directors on research initiatives.

In February 1999, 60 applicants were invited to submit proposals for consideration. Twenty of those were approved (see p. 4). This year's RFP is a direct extension of the previous one.

Chair of the RAC is Dr. Robert Norman of the University of Waterloo. He is excited about the development of the research program and the WSIB's commitment to high-quality research.

"There has been a tremendous acknowledgment of the need for solid research on occupational health and safety problems in Ontario, if valid indicators are the 100 letters of intent to submit proposals we received, the requests to talk about research I have had from workplace parties and safe workplace associations, and the attendance at the research consultation day we held in November. About 300 people were there, representing employers and worker groups, occupational health and safety professionals, government, and university researchers. Their input was highly informed, thoughtful, and helpful, and we have tried to incorporate it into our work."

"The RAC is extremely pleased with the WSIB's support for this initiative," says Norman, "but we still have many difficult tasks to deal with. For example, we have to find ways to ensure that existing and new research knowledge is used effectively, and we must encourage even more involvement in the research initiative by employers, both by identifying priorities and by providing their work sites for field research projects."

If you're interested in reading the RFP, contact the Research Secretariat c/o Workplace Safety and Insurance Board, 21st Floor, 200 Front Street West, Toronto, Ontario M5V 3J1. Call the Secretariat at (416) 344-6913, or toll-free at 1-800-387-0750, ext. 6913.

**"There has been a tremendous acknowledgment of the need for solid research on occupational health and safety problems in Ontario... [We're] extremely pleased with the WSIB's support for this initiative, but we still have many difficult tasks to deal with."**

**Dr. Robert Norman, Chair  
Research Advisory Council**

## Research projects funded in 1999

Here are the titles of the 20 research projects funded by the Research Advisory Council in 1999. For more details, visit the WSIB's website at [www.wsib.on.ca](http://www.wsib.on.ca). You'll find a description of each study, the budget allocated to each, and the name of the principal investigator on each project.

- Hearing protectors, safety glasses and respiratory protective equipment in combination: effect on sound attenuation.
- The change from 8 to 10 hour shifts at an underground mine: identifying the effects on sleep, performance, safety and social interactions and implementing a workplace promotion program.
- Towards developing better rehabilitation protocols for low-back-injured workers.
- Evaluation of participatory ergonomic interventions in large and small business.
- CAW/McMaster work-related health and safety risks study.
- Dealing with work-related muscular-skeletal disorders (WMSD) in the Ontario clothing industry.
- Assessment of a person's ability to function at work.
- Back pain and work during pregnancy: identification of problems and biochemical analysis.
- A collaborative investigation of the incidence of cancer among workers in an auto parts plant.
- Return to work in small workplaces: workers' and employers' perspectives.
- Continuous monitoring of isocyanate monomers.
- Evaluation of diesel particulate filter systems at Inco's Stobie Mine in Sudbury.
- Carpal tunnel syndrome - morbidity and management outcomes in Ontario.
- Effects of job strain, hospital organizational factors and individual characteristics on work-related disability among nurses.
- Study to improve diagnostic methods for repetitive strain injuries such as Carpal Tunnel Syndrome.
- Occupational histories of Essex County cancer patients.
- The needs and experiences of injured workers: a participatory research process.
- Outcomes in contact dermatitis.
- The role of the supervisor in accident prevention.
- Underground mobile trackless equipment visibility investigation.

Copies of the proposals for each of these projects are available in the WSIB Reference Library, 17th Floor, 200 Front Street West, Toronto.

## Accident-reporting (cont'd from p.1)

An employer now reports an accident *only* if the worker requires health care and/or:

- is absent from regular work, or earns less than regular pay for regular work (e.g. part-time hours)
- requires modified work at *less than regular pay*
- requires modified work at *regular pay* after the seventh calendar day, or on the next scheduled shift after the seventh calendar day, following the date of the accident.

Why seven calendar days? The WSIB believes that if a worker is fit to do modified work at regular pay, then hopefully the injury will heal within a week. If the worker requires modified work *past* that point, that's usually an indication that the injury may be more severe than was initially suspected. Regardless of whether the worker actually *does* seek health care, the WSIB assumes he or she should, and therefore requires the employer to report.

For more information about this policy, call (416) 344-4330, or 1-800-387-0750, ext. 4330. Ask for the Policy Analyst On-Call.

# POLICY REPORT



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# POLICY REPORT

Vol. 13 No. 2 September 2000

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## Tax cuts and insurance benefits



### Recent tax cuts may increase WSIB benefits

In its February 28, 2000 budget the federal government announced a decrease in the personal income tax rate and the provincial government made a similar announcement in its May 2, 2000 budget. The two levels of tax cuts, that took effect July 1, 2000, will likely mean an increase in certain insurance benefits.

#### Applying the tax adjustment

The WSIB calculates most benefits based on a percentage of an injured worker's pre-injury net average earnings (NAE)\*, which are themselves determined by deducting from the worker's gross earnings the probable CPP/QPP premiums, Employment Insurance (EI) premiums, and income tax the worker would pay.

Income tax payable is based on federal and provincial tax rates and, since the federal and provincial governments have reduced the amount of payable income tax, the WSIB's calculations will incorporate these reductions, thereby increasing the amount of a worker's NAE. This may result in an increase in benefits.

#### Benefits affected

If the payments span, or start on or after July 1, 2000, workers may see an increase in:

- all benefits for accidents that occurred between April 1, 1985 and January 1, 1990, inclusive
- all temporary disability benefits for accidents that occurred on or after January 2, 1990
- all loss of earnings benefits for accidents that occurred on or after January 1, 1998

- all future economic loss (FEL) supplements, and
- all monthly survivors' benefits for deaths that occurred on or after April 1, 1985.

The following benefits will be eligible for the new tax rates **only** if the payment starts on or after July 1, 2000:

- FEL benefits, and
- FEL benefits affected by a material change.

#### Benefits not affected

The following benefits are **not** affected by these tax cuts:

- all benefits (including monthly survivors' benefits) for accidents before April 1, 1985
- Bill 165 benefits (s.147(14))—\$200 payment
- Bill 162 Old Age Supplement (OAS) benefits
- non-economic loss (NEL) benefits
- FEL benefits (including FEL benefits affected by a material change) if the payment start date is **prior to** July 1, 2000
- lump sum payments made to dependants, and
- burial benefits.

The WSIB will notify, in writing, all workers or dependants whose benefits are affected by the tax cuts.

\*

- 1 Benefits paid for accidents or occupational diseases occurring before April 1, 1985 are based on 75% of an injured worker's pre-injury gross earnings.
- 2 Benefits paid for accidents or occupational diseases occurring on or after April 1, 1985 and before January 1, 1998 are based on 90% of an injured worker's NAE.
- 3 Benefits paid for accidents or occupational diseases occurring on or after January 1, 1998 are based on 85% of an injured worker's NAE.

# Highlights of approved policies

## Industrial Maintenance and Repair Contracting

The WSIB has revised policies in the Employer Classification Manual (ECM) regarding the business activity of industrial maintenance and repair (IMR). By adding a new classification unit (CU) G-707-05 (4259-000)—Industrial Maintenance and Repair Contracting, the WSIB now distinguishes between two kinds of IMR in the classification scheme.

### Service Contracts vs. One-off

The first kind of IMR is described in the new CU and includes service contracts in which the contractor agrees to maintain (and/or, when necessary, repair) equipment for a “specified duration,” (e.g., six months, one year, etc.). The contract may stipulate a lump sum payment for the period, or the payment may be tied to the frequency and/or nature of the IMR. A “specified duration” can be any length of time as long as the duration is clearly specified in the contract and the service does not fall under the “one-off” category.

### Example: Service Contract

*A steel manufacturer wants around-the-clock maintenance and repair available on its industrial plant machinery for two years. The bidders include a manufacturer of industrial machinery with a D-403-03 classification, and a machinery wholesaler classified in F-670-01, both of whom perform IMR, as well as a plumbing contractor in G-707-02. In bidding on the contract, all three employers take into account that if they win the contract, the labour involved will be classified in G-707-05 and not the company’s usual CU.*

“One-off” IMR, on the other hand, is a contract or verbal agreement to perform IMR on a piece of machinery or equipment once only. No further maintenance or repair (except for warranty tied to a repair) is included in the agreement. This kind of IMR is excluded from G-707-05 and remains classified in the CU that has always included maintenance and repairs to the particular machinery or equipment in question.

### Example: One-off

*The same manufacturer has a breakdown in a smelting unit. The repair must be done immediately. The manufacturer contacts the same three employers as in the first example to get quotes. The three employers provide quotes on the basis that the work will be classified in the same CU as their main business activity.*

### Competitive inequities reduced

Service contracts are frequently bid on by employers whose usual business activities are classified in different rate groups, sometimes with widely varying premium rates. Before the WSIB implemented these revisions, employers priced the service contracts according to the premium rate for their main business activity. This created competitive inequities among the bidding employers for the same kind of work. A standard CU for service contracts should eliminate inequities in this area.

### Special operation: Millwrighting and Rigging

IMR on large-scale industrial plant machinery and other large-scale machinery or equipment may involve millwright and rigging work in order to dismantle and re-install the parts intended for IMR. As a special operation under Ontario Regulation 175/98, this dismantling and re-installing work is always considered a separate business activity, and is classified in G-737-01 (4255-000)—Millwright and Rigging Work.

The requirement to segregate large-scale dismantling and re-installation work applies to both IMR service contracts and to one-off IMR. If the labour for millwrighting and rigging is not segregated from the IMR itself, the entire aggregated payroll (including the millwrighting and rigging) is classified in the CU with the highest premium rate.

Once the items to be maintained or repaired are dismantled, and providing that the payrolls are properly segregated, IMR on the items is classified in whatever CU applies to this kind of IMR, (i.e., service contract or one-off). This is true whether the IMR is performed on-site or in an off-site machine shop.



## Loss of Retirement Income Benefit (18-03-06)

After a worker has received loss of earnings (LOE) benefits for 12 continuous months, the WSIB sets aside an amount equal to five percent of every subsequent LOE payment to replace the worker's lost retirement income. In addition to the WSIB's mandatory contribution, the worker may elect to voluntarily contribute five percent from every LOE benefit payment made after the 12-month mark.

The WSIB's mandatory contribution and the injured worker's voluntary contribution, if any, are deposited into a fund and invested. The loss of retirement income (LRI) benefit becomes payable when the worker reaches age 65, or upon the worker's death, whichever comes first.

The policy and guidelines mirror Regulation (Reg. 562/99 of the Act and further explain:

- how the LRI benefit will be paid out, depending on which one of the three payment schemes the worker selects
- that indexing the benefit only affects how the benefit is distributed over the payment period (i.e., increasing the amount of the later payments decreases the amount of the earlier payments), and
- that the rules governing the payment of benefits prior to age 65 depend on whether the worker's death was work-related or not, and whether the worker made voluntary contributions.

## Retroactive Adjustments (4-02-06)

The WSIB has revised the policy on Retroactive Adjustments, now called Employer Premium Adjustments. For a copy of the revised policy visit the WSIB website—<http://www.wsib.on.ca>.

### Notice to subscribers

If you save your issues of *Policy Report*, you can get an up-to-date index by calling PolicyPublications.

## 2000 Indexation of allowances paid to severely impaired workers

The payment rates for some of the benefits and expenses paid by the WSIB are not specifically referred to in the Act and therefore, must be regularly set and adjusted (i.e., maximum burial rate, mileage, meals, witness fees, escort fees, independent living allowance).

Rate changes for several allowances paid to severely injured workers have been approved for this year. The new rates do not apply to allowances that are processed in 2000 but are being paid for time periods prior to January 1, 2000.

Benefit	1999 Rate
Independent Living Allowance	\$2828/year
Personal Care Allowance	Skilled Rate: \$15.25/hour Personal Rate: \$9.53/hour *Basic/Supervisory Rate: \$6.85/hour (*set at minimum wage)
Guide Dog Allowance	\$766.08/year

Benefit	2000 Rate
Independent Living Allowance	\$2893.04/year
Personal Care Allowance	Skilled Rate: \$15.60/hour Personal Rate: \$9.74/hour *Basic/Supervisory Rate: \$6.85/hour (*no change to minimum wage)
Guide Dog Allowance	\$783.69/year

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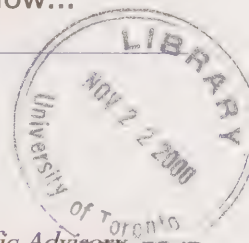
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On Page 2...

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documents revised

Did you know...

## Chronic Pain Study



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One of the most comprehensive studies ever done on work-related chronic pain has resulted in guidelines that will help workers and employers reach healthier outcomes in the workplace.

The two-year independent study was commissioned by the WSIB and was carried out by scientific experts and representatives from Ontario's employer and worker communities.

**The result is four recommendations that will be implemented by the WSIB:**

1. The *Workplace Safety and Insurance Act* and the WSIB will treat chronic pain the same way they treat any other workplace injury or illness.
2. The WSIB will investigate and report on the panels' recommendations for:
  - more effective treatment, management, and return to work strategies, and
  - a revised approach to rating permanent impairment.
3. The WSIB will conduct a review in five years to assess:
  - the effectiveness of any prevention and management strategies that were implemented as a result of the initiative,
  - any new scientific evidence about the work-relatedness of chronic pain, and
  - any developments in the courts concerning compensation law.
4. The WSIB will support continued research into the treatment and management of chronic pain.

Chronic pain is defined as pain that persists six months after an injury and beyond the usual recovery time of a comparable injury; this pain may continue in the presence or absence of demonstrable pathology.

—The Chronic Pain Scientific Advisory Panel

The members of the *Chronic Pain Scientific Advisory Panel* and *Chronic Pain Policy Advisory Panel* were

nominated by their peers because of their expertise in chronic pain or compensation issues.

Both panels were chaired by Brock Smith who has held several senior positions with the Ontario government including the position of Deputy Minister of Treasury and Economics.

### Chronic Pain Scientific Advisory Panel

Robert Bernstein, PhD, MD, CM, CCFP, FCFP, University of Ottawa  
Claire Bombardier, MD, FRCP, University of Toronto  
Angelica Fargas-Babjak, MD, FRCPC, McMaster University  
Judith Hunter, BSc(PT), MSc, PhD candidate, University of Toronto  
Klaus Kuch, MD, FRCP, University of Toronto  
Silvano Mior, DC, FCCS(C), Canadian Memorial Chiropractic College  
Dwight E. Moulin, MD, FRCPC, University of Western Ontario  
Warren R. Nielson, PhD, C Psych, University of Western Ontario  
Robert Teasell, MD, FRCPC, University of Western Ontario  
Robin Weir, RegN, PhD, McMaster University

### Chronic Pain Policy Advisory Panel

Phil Biggin, Union of Injured Workers of Ontario Inc.  
Mary Cook, Occupational Health Clinic for Ontario Workers  
Dr. David Corey, Health Recovery Group  
David Craig, Brampton Community Legal Services  
Dr. Edward Gibson, Occupational Health Physician  
Sherri Helmka, Employers' Advocacy Council  
Kim Hopps, Management Board Secretariat  
Gerry Le Blanc, United Steelworkers of America  
Tracy McPhee, Alliance of Manufacturers and Exporters  
Denise K. Peters, Council of Construction Associations  
Ronald R. Tasker, MD, MA, FRCS(C), The Toronto Hospital

For a copy of the *Report of the Chair of the Chronic Pain Panels*, visit the WSIB website—<http://www.wsib.on.ca> or contact Policy Publications at (416)344-4355 or toll free at 1-800-387-0750, ext. 4355

## Offences and Penalties documents revised

The WSIB has revised its policies, which address how the WSIB will respond to cases of suspected fraud or non-compliance, to reflect the provisions found in Bill 99. As a result, four policy documents were revised and transferred from the pre-Bill 99 OPM to the new OPM.

References to the pre-1998 *Workers' Compensation Act* were revised in order to reflect the provisions of the *Workplace Safety and Insurance Act*.

The most significant changes are found in document **11-02-05, Employer:**

Guidelines regarding time limits have been removed because they repeated information already found in 11-02-02, General. Cross-references have been inserted in their place.

Further, new provisions have been added under "Recovery Measures". The WSIB can now make retroactive adjustments to an employer's account, in any year in which premiums were payable, if the Special Investigations Branch finds that the employer has committed wrongdoing. Civil or criminal charges need not be laid for the WSIB to initiate recovery action.

Additionally, minor changes were made as follows:

### **11-02-02, General**

A guideline has been added that will provide direction in case of conflict between administrative action and criminal prosecution.

### **11-02-03, External Suppliers of Goods and Services**

Guidelines regarding preliminary investigation have been removed because they repeated information already found in 11-02-02, General. Cross-references have been inserted in their place.

### **11-02-04, Claims**

References have been updated as mentioned above, but no additional changes have been made.

These four policies replace the existing policies, so their application dates remain the same — they apply to all incidents of suspected wrongdoing discovered on or after January 1, 1997.

## Did you know...

... that the WSIB accepts audio/visual recordings as evidence, if they:

- provide new or more complete information than is already on file
- are relevant and pertain to the WSIB's duty to hear, examine, and decide issues under the Act, and
- are authenticated?

For more information refer to document 11-01-08, Audio/Visual Recordings in the OPM.

# POLICY REPORT

**WSIB** Workplace Safety & Insurance Board  
ONTARIO  
**CSPAAT** Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

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# POLICY REPORT

Vol. 13 No. 4 December 2000

**WSIB**  
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Workplace Safety &  
Insurance Board

Commission de la sécurité  
professionnelle et de l'assurance  
contre les accidents du travail

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New policy,

## Employer Premium Adjustments changes how WSIB reviews premiums

### Background

In the spring of 2000, two factors led the WSIB to review the *Retroactive Adjustments* policy (08-01-09 in the Pre-Bill 99 Operational Policy Manual (OPM)) and replace it with the *Employer Premium Adjustments* policy (14-02-06 in the new OPM):

- Firstly, many WSIB customers felt that the *Retroactive Adjustments* policy was unfair, inflexible, and financially punitive, especially in cases where retroactive adjustments were made to correct prior errors.
- Secondly, the WSIB had experienced a significant increase in the number of classification changes arising directly out of the implementation of the new Service Delivery Model.

As a result, the WSIB felt that it was necessary to revise the policy in order to administer premium adjustments more efficiently and effectively. While the policy was under review, the WSIB felt that it was neither fair nor appropriate to make classification changes; consequently, it suspended implementation of any new classification changes until after the revised policy was formally approved.

### Why premiums are reviewed

The WSIB initiates a review of an employer's premium, if either the WSIB or the employer believes that the employer's premium may have been incorrectly calculated, based on proper application of the WSIB policies in effect at the relevant time.

### Changes that may result in a premium adjustment

An employer's premium may need to be adjusted due to a change in one or more of the following:

- the employer's classification
- the employer's insurable earnings
- the employer's previously reported or paid premiums
- optional insurance
- worker status for executive officers, independent operators or sub-contractors
- interest charges, or
- non-compliance penalties.

### Application of the revised policy

The *Employer Premium Adjustments* policy applies to:

- all classification decisions made on or after July 1, 2000 if the notification date was on or after May 15, 2000, and
- all other decisions made on or after July 1, 2000.



Notification date

“The notification date” is the date on which the WSIB initiates a review of the employer’s premiums. This is the first date on which the WSIB:

- phones or visits the employer regarding the review, or
- receives any correspondence requesting (via the post, fax, or e-mail) some type of change.

**Note:** For classification changes, this policy applies to those reviews initiated by the WSIB on or after May 15, 2000.

Similarly, when an employer (or the employer’s representative) requests a review, the correspondence must have a receipt date of May 15, 2000 or later for this policy to apply (this date can be the mailroom stamp date, or the date recorded by a fax machine or an e-mail).

The notification date is very important because the WSIB uses it to establish its timelines for adjusting prior premiums.

Timeline for making adjustments: two-year rule

The WSIB uses one of two possible dates on which to base its timelines for making premium adjustments, either:

- back to the beginning of the notification year, plus two full calendar years prior to the notification year, or
- back to the actual date of the change which caused the adjustment to take place, if the change occurred within the two years prior to the notification year.



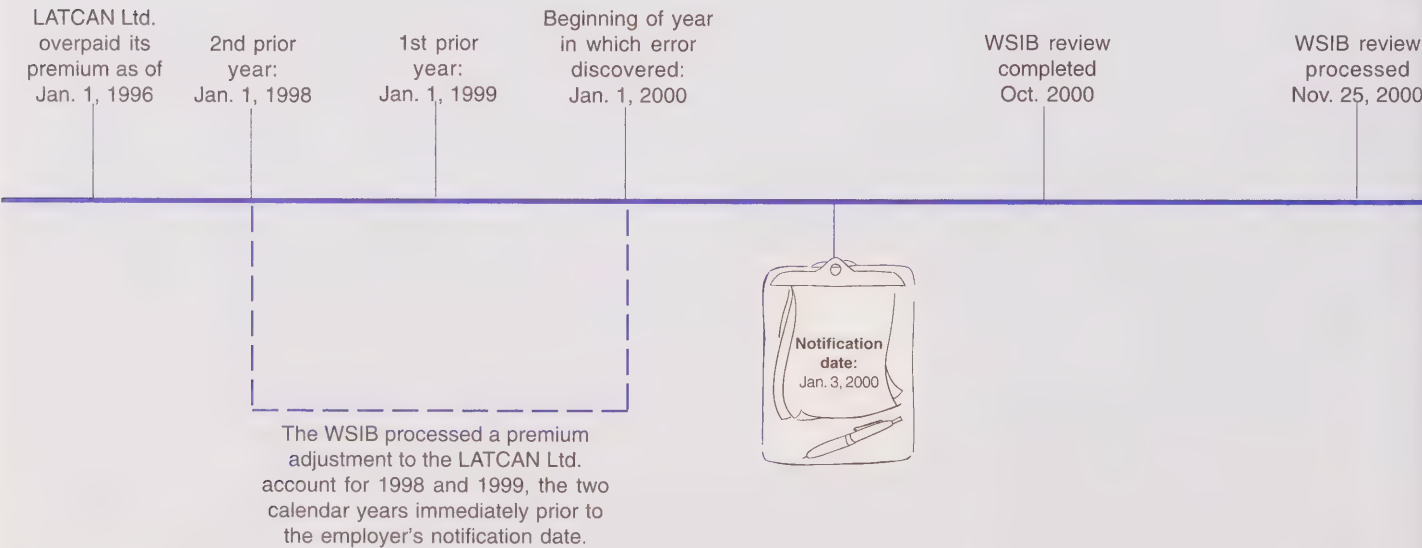
Examples of the general two-year rule

Example 1

For four years (1996-1999), LATCAN Ltd. overpaid its premium because it did not deduct excess earnings for workers who earn above the WSIB insurable earnings ceiling. On January 3, 2000, LATCAN Ltd. discovered the problem and notified the WSIB. The WSIB completed its review in October and processed the review on Nov. 25, 2000. The WSIB made a premium adjustment to the LATCAN Ltd. account for 1998

and 1999, the two years immediately prior to the year of the employer’s notification date. No adjustments were made for 2000 since the employer reported the excess earnings correctly. The credit adjustment to the employer’s premium was made for 1998 and 1999 (two years).

If LATCAN Ltd. had failed to deduct excess earnings only for the 1999 year, then the WSIB would have corrected the premium for 1999 only.





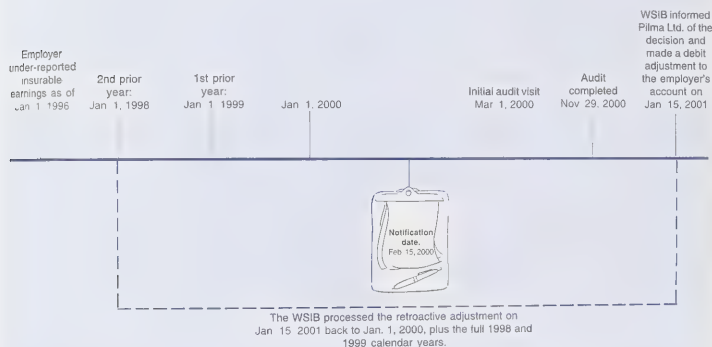
## Examples of the general two-year rule (cont'd)

### Example 2

The WSIB audited Pilma Ltd. in 2000. The audit revealed that this employer under-reported insurable earnings dating back four prior years) to January 1, 1996, as they had inadvertently miscalculated their contractor's earnings. It was determined that the firm did not fail to fully disclose information to the WSIB. As a result of this error, the employer had been paying lower premiums since 1996.

Pilma was notified of the audit on February 15, 2000. The initial audit visit took place on March 1, 2000. The audit was not completed until November 29, 2000. The debit adjustment and the decision were not communicated to the employer until January 15, 2001.

The premium debit adjustment was made for 1998 and 1999, the two full calendar years immediately prior to WSIB's notification date of the audit and from January 1, 2000 onwards.



## Did you know...

- that the WSIB **does not pursue** the recovery of a benefit related debt if
- the debt is a result of a previous entitlement decision overturned due to a reconsideration or appeal\*
- the debt is a result of an administrative error and the debtor could not have reasonably been aware of the error
- the debtor is not notified of the debt within three years of the date the debt is considered due and owing to the WSIB\*
- the WSIB determines that recovery action will result in severe, long-term financial hardship?

\*This, however, does not apply to circumstances of fraud, and/or false or misleading statement(s) or representation, in connection with a claim for benefits or an attempt to obtain payment for goods or services provided to the WSIB, or failure to report material change in circumstances.

## Four exceptions to the two-year rule

Exception	Explanation
<b>Classification changes</b>	For classification changes (i.e., where the employer is found to have been placed in the incorrect classification category), premium adjustments are generally made back to the <b>beginning of the calendar year</b> that includes the notification date, if the notification date was on or after May 15, 2000. See examples 3 and 4.
<b>Provisional premiums</b>	The WSIB may make premium adjustments to an employer account to correct provisional premiums in any prior year in which a provisional premium was issued. If the WSIB has not received sufficient information about a firm in order to establish a premium to be paid, the WSIB estimates a provisional premium based on past reported payroll or premiums. If the WSIB does not have any past information about the firm's payroll or premiums, the estimate could end up being too high or too low.
<b>Lack of full disclosure</b>	If the WSIB finds that there has been a lack of full disclosure in an employer's account on any premium-related issue requiring a correction, the WSIB may use its discretion to make premium debit adjustments. This adjustment to an employer's account can only go back to a <b>maximum of five prior calendar years</b> . Examples of lack of full disclosure include: <ul style="list-style-type: none"> <li>providing incomplete or inaccurate information to the WSIB, or</li> <li>otherwise delaying, withholding, or not fully disclosing relevant information, or</li> <li>not acting on information provided to them by the WSIB that directly affects their premium.</li> </ul> See also, "Additional Information".
<b>Offences or fraud</b>	The WSIB may make premium debit adjustments to an employer's account <b>beyond five years or in any year</b> , if the Special Investigations Branch (SIB) or Legal Branch finds that the employer has committed either: <ul style="list-style-type: none"> <li>a fraudulent act, or</li> <li>an offence under the Act.</li> </ul> See also, "Additional Information".

## Additional Information

For guidelines used by the Special Investigations Branch (SIB) in cases of suspected fraud please refer to the following policies in the new OPM:

Policy Number	Title	Description
11-02-02	Offences and Penalties, General	This policy describes the <b>general</b> guidelines the WSIB follows when WSIB staff, employers, workers, their spouses or dependants, or external suppliers of goods and services have committed an offence.
11-02-05	Offences and Penalties, Employer	This policy describes the <b>specific</b> guidelines the WSIB follows when an employer has committed an offence.

## Examples of classification changes

### Example 3 — A classification change:

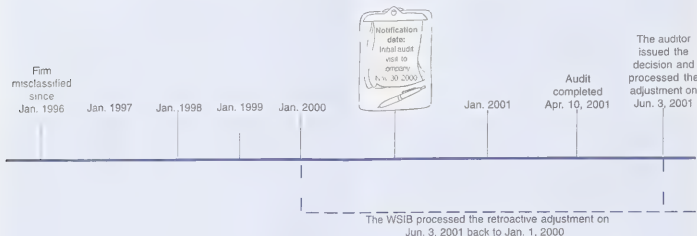
The WSIB audited Ontario Corp. The notice to audit was issued on November 15, 2000 with the initial visit taking place on November 30, 2000. The audit was completed on April 10, 2001.

It was discovered during the audit that the firm was misclassified under rate group 210: Poultry Products for about five years (since the beginning of 1996). The firm did previously provide the correct information to the WSIB about their operation

The auditor determined that the correct classification for this firm's operation was RG 207: Meat & Fish Products, which has a significantly higher rate. Therefore, the firm had been paying a lower premium rate for five years.

The auditor processed the adjustment in the account and issued the decision on June 3, 2001.

The reclassification took effect on January 1, 2000 (i.e., at beginning of year of notification).

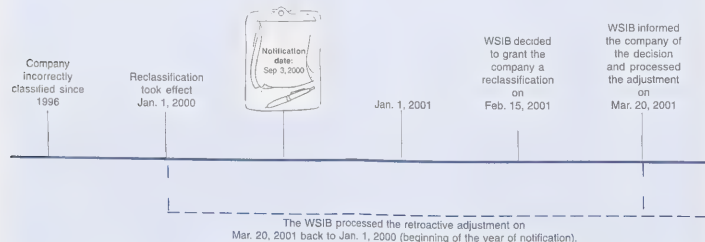


### Example 4 — A classification change:

On Time Deliveries felt that it had been incorrectly classified under the Trucking rate group (#570) since 1996. On September 3, 2000, the WSIB received a notice from On Time Deliveries requesting a classification change. The company requested a reclassification to the rate group for Courier Services (#577). Since the issue was very complex, the WSIB had to gather additional information — a process that took about six months.

On February 15, 2001, the WSIB decided to grant the company a reclassification from RG 570 (under which the company was paying a higher premium rate) to RG 577. On March 20, 2001, the WSIB informed On Time Deliveries and adjusted their account.

The reclassification took effect January 1, 2000 (i.e., at the beginning of the year of notification).



## Season's Greetings

*May your holidays be filled with  
peace, love and happiness and may  
your New Year bring you every joy.  
from the Policy and  
Research Division*

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# POLICY REPORT

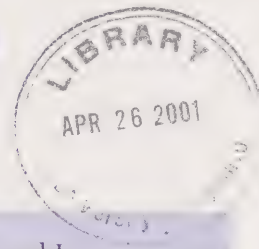
Vol. 14 No. 2 March 2001

**WSIB**  
ONTARIO  
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Workplace Safety &  
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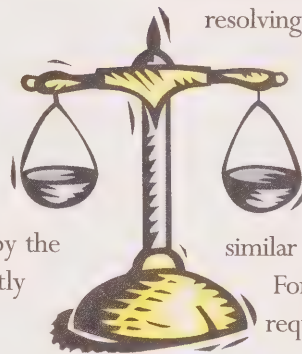
## Merits and Justice a new policy



Section 119(1) of the *Workplace Safety and Insurance Act* (the Act) states that the Workplace Safety and Insurance Board (WSIB) “shall make its decision based upon the merits and justice of a case and it is not bound by legal precedent.” Over the years, this important legal provision, which applies to all WSIB decisions, has caused some confusion, both internally and externally. This issue of *Policy Report* outlines why the merits and justice provision was included in the Act and why the WSIB developed a policy for it — operational policy 11-01-03, *Merits and Justice*. Because the concept of “merits and justice” is quite abstract, this issue of *Policy Report* also highlights the main principles of the policy, and illustrates the principles using scenarios with questions and answers.

### Why is the merits and justice provision included in the Act?

The merits and justice provision was included in our legislation primarily to reinforce the fact that the WSIB is an administrative tribunal. An administrative tribunal is an agency, created by a statute, which has been given the power to decide matters that would normally be decided by the courts. The merits and justice provision, in slightly different form, has been a part of the WSIB's legislation since 1917.



courts would have the task of determining entitlement and resolving disputes arising from the various laws; having to do so could create a major backlog in the courts.

### How the WSIB as an administrative tribunal is similar to a court

Administrative tribunals, such as the WSIB, are similar to courts in some ways and different in others.

For example, both the WSIB and the courts are required to:

- allow parties to be represented by a lawyer or other representative,
- give disputing parties the right to present their cases at a hearing,
- provide adequate notice of all proceedings (e.g., the hearing's time, date, and place; time limits for appealing decisions or complying with legislative requirements),
- make all decisions, and conduct all proceedings, in a way that is fair and open to all the parties,
- ensure that decisions are based on evidence, and
- provide reasons for all decisions.

Administrative tribunals were created as an efficient way for governments at all levels to enforce legislative requirements and to resolve disputes arising from those requirements. Both governments and the courts recognized that with their specialized expertise, administrative tribunals could resolve disputes more quickly and in a more cost-effective manner than could the courts.

If administrative tribunals such as the WSIB or the Employment Insurance Commission had not been created, the

## How the WSIB as an administrative tribunal differs from a court

One of the most important ways that the WSIB, as an administrative tribunal, differs from courts is that its decisions do not have to follow legal precedent. What this means is that in recognition of their own expertise, administrative tribunals have the flexibility to depart from previous decisions where the facts and circumstances of individual cases, or compelling reasons of public policy demand it. However, the WSIB must observe and apply the appropriate legislative provisions and WSIB policies to each case it reviews.

Another important way that the WSIB, as an administrative tribunal, differs from courts is that courts do not have the authority to review WSIB decisions. In this respect s.118 of the Act provides that the WSIB has exclusive jurisdiction to decide all matters and questions arising under the Act, and that a WSIB decision “is not open to question or review in a court.”

Lastly, the WSIB as an administrative tribunal has the power to develop policies when the Act is silent or ambiguous, or when it permits a number of possible interpretations. These policies help decision-makers apply the Act fairly and provide guidance to external stakeholders on how the WSIB is likely to rule on a given set of facts.

When applying policy, WSIB decision-makers first consider whether the case falls within the application date of the policy and then whether the facts of the case fall within the scope of the policy. If the facts of the case pertain to one or more policies, the decision-maker must apply each of those policies when making a decision. Of course, policy can never depart from the provisions of the Act — should the two conflict, the Act prevails. If a decision-maker finds that the facts of the case are not covered by existing policy, the case must be decided on its particular facts, in accordance with the general provisions of the Act.

## Why a policy on merits and justice?

A review of past WSIB decisions shows that some confusion exists as to the meaning of the merits and justice provision, and when and how it should be applied. For example, some WSIB



decision-makers believe that the merits and justice provision allows them to ignore applicable WSIB policy if the end result of their decision is “just.” The merits and justice policy was developed in order to remove this confusion and to help decision-makers apply this important provision.

## Principles of the merits and justice policy

In the context of the WSIB, basing a decision on the merits and justice of the case means that **decision-makers must take into account all of the relevant facts and circumstances of the case.** Once they have done so, decision-makers must adhere to the following three principles:

- 1 First and foremost, they must apply all of the relevant provisions of the Act, without exception.
- 2 Second, they must apply all relevant WSIB policies providing the case does not have any exceptional circumstances.
- 3 Finally, if there are exceptional circumstances, decision-makers may depart from relevant WSIB policy, **only** if the application of such policy would lead to an unfair or absurd result that the WSIB could never have intended. In these cases, decision-makers must clearly identify the exceptional circumstances and explain in the decision why the relevant policy is not applicable.

By applying relevant legislative and policy provisions to similar situations, decision-makers ensure that:

- similar cases are adjudicated in a similar manner,
- each participant in the system is treated fairly, and
- the decision-making process is consistent and reliable.

When determining entitlement to a disease claim, a decision-maker considers the worker’s medical condition and exposure at work, the up-to-date medical and scientific information, any pertinent non-occupational factors, and all of the relevant policies.

## Policy application examples

Because the concept of “merits and justice” is quite abstract, the next section illustrates each of the three principles of the merits and justice policy using a scenario, a question, and an answer. Given that the WSIB has three policy branches: Benefits Policy, Revenue Policy, and Medical and Occupational Disease Policy, and given that each branch deals with different situations, we have illustrated each principle with examples from each branch.



## Principle 1:

### Decision-makers must apply all relevant provisions of the Act, without exception

#### *Example from the Benefits Policy Branch*

**S**cenario: A worker has been receiving loss of earnings (LOE) benefits for more than 72 months. The amount of the LOE payment is equal to 12% of the payment the worker would receive for full loss of earnings. The worker tells the decision-maker that he needs a new car and would like a commutation of his LOE benefit so that he can buy the car.

**Q:** Can the decision-maker grant the worker's request for a commutation?

**A:** No. In this situation, the decision-maker cannot grant the worker's request for a commutation. Although the decision-maker may feel sympathetic to the worker's request for a commutation, s. 62(2)(a) of the Act states that a commutation of LOE benefits will only be allowed when the amount of the worker's LOE payment is 10% or less of his/her full LOE payment.

#### *Example from the Revenue Policy Branch*

**S**cenario: ABC Manufacturing Inc. (ABC) was sold to G. Smith Limited (Smith) on February 1, 2001. The WSIB is holding Smith liable for \$8,000 in overdue premiums that ABC did not pay to the WSIB before the sale of the business. Smith believes that G. Smith Ltd. should not be responsible for ABC's overdue WSIB premiums, as the two businesses were separate and unrelated prior to the purchase. Consequently, Smith has asked the WSIB to relieve them from paying ABC's unpaid premiums.

**Q:** Should the WSIB relieve Smith from paying ABC's unpaid premiums?

**A:** No. Section 146 of the Act states that the purchasing employer is liable for the previous employer's unpaid premiums accumulated prior to the sale and purchase of the business. Thus, to comply with s.146 of the Act, the decision-maker has no choice but to pursue Smith for unpaid WSIB premiums.

#### *Example from the Medical and Occupational Disease Policy Branch*

**S**cenario: A worker in the automotive industry whose task for the last three years has been to manufacture and assemble asbestos brake linings develops primary pleural mesothelioma. The employer provides expert scientific evidence that such a short latency interval (from first exposure to development of the disease) is not compatible with a work-related cause of the cancer.

**Q:** In this case, can the decision-maker accept the employer's scientific evidence to deny the worker's claim?

**A:** No. In spite of the scientific evidence, the decision-maker must allow the claim, because the worker is covered under Schedule 4 of Regulation 175/98 to the Act: The worker worked in a process listed in Column 2 and has the disease specified in Column 1. Therefore, the Act provides an irrefutable presumption of work-relatedness under s.15(4). This worker's disease is deemed to have occurred due to the nature of the worker's employment in spite of evidence to the contrary.

## Principle 2:

If there are no exceptional circumstances, decision-makers must apply all relevant WSIB policies

### *Example from the Benefits Policy Branch*

**S**cenario: A decision-maker has to determine whether an employer is obligated to re-employ a worker. The issue depends on the number of workers regularly employed by the employer. Section 41(2) of the Act exempts employers who regularly employ fewer than 20 workers. The decision-maker obtains information which indicates that the employer regularly employs 15 full-time workers and 10 part-time workers. The employer urges the decision-maker to include only his full-time workers in the calculation stating that otherwise he would not be able to run his business efficiently.

**Q:** Can the decision-maker include only the employer's full-time workers in the calculation and absolve the employer from the obligation of re-employing the injured worker?

**A:** After reviewing WSIB policy 19-04-02, *Re-employment Obligation*, the decision-maker concludes that the facts of the case are addressed by the policy. The policy states that both full-time and part-time workers must be included when calculating how many workers an employer regularly employs. Recognizing that there are no exceptional circumstances, and that the application of the policy would not lead to any absurd or unintended results, the decision-maker applies the policy to the facts at hand and decides that the employer has an obligation to re-employ the worker.

### *Example from the Revenue Policy Branch*

**S**cenario: An employer asks for a reclassification of its nursing home operation from Classification Unit 851-01: Nursing Home Operations to 853-01: General Hospitals on the basis that it has an excellent New Experimental Experience Rating plan (NEER) record and an injury record closely matching that of 853-01.

**Q:** Does the decision-maker have the authority to reclassify this nursing home operation?

**A:** No. The WSIB classification policy places the type of operation carried out by this employer under RG 851-01. Therefore, the decision-maker must use 851-01 as the appropriate classification for this employer's nursing home operation, regardless of its outstanding injury record. Individual employer operations are classified according to the WSIB's classification scheme. The employer's business activity is the sole criterion for classification. The WSIB does not take individual employer's risk, claim experience, or accident cost history into account when classifying the employer's operations. However, since this employer has a good accident cost experience record, it will likely be eligible to receive refunds under the NEER plan.

### *Example from the Medical and Occupational Disease Policy Branch*

**S**cenario: A worker has a hearing loss of 20 decibels (dB) in both ears and claims for occupational noise-induced hearing loss (NIHL).

**Q:** Can the decision-maker approve benefits for this worker?

**A:** No. Since there are no exceptional circumstances, the decision-maker cannot disregard WSIB policy 04-03-06, *Occupational Noise-Induced Hearing Loss*, which requires a minimum hearing loss of 25 dB in both ears before there is entitlement to benefits.



# 2001 Table of Rates

Every year, the WSIB reviews and sets the following rates. This is done after conducting an external survey of costs for each rate. The only exception is the minimum burial rate. This rate is indexed annually according to the alternate-indexing factor, the Consumer Price Index (CPI).

The rates apply as of January 1, 2001.

For more information on the rates please refer to the policy documents referenced in the table.

Benefit	New Rate	Old Rate	OP Document
<b>Independent Living Allowance</b>	\$2974.05/yr	\$2893.04/yr	17-06-02
<b>Personal Care Allowance</b>			17-06-05
*General Attendant Rate	\$6.85/hr	\$6.85/hr	
Personal Attendant Rate	\$10.01/hr	\$9.74/hr	
Skilled Attendant Rate	\$16.04/hr	\$15.60/hr	
Bookkeeping Fee	\$720.00 annually	\$720.00 annually	
*set at minimum wage			
<b>Clothing Allowance</b>	min. damage \$255.55 max. maj. damage \$511.12 max.	min. damage \$255.55 max. maj. damage \$511.12 max.	17-05-02
<b>Escorts</b>	\$51.00 /day	\$51.00/day	17-01-08
<b>Burial Expenses</b>	\$2,246.00 minimum \$10,122.00 maximum	\$2,184.84 minimum \$8,650.00 maximum	18-01-05 20-03-02
<b>Guide and Support Dog Allowance</b>	\$805.63 annually	\$783.69 annually	17-06-04
<b>Meal Allowance</b>			17-01-09
Breakfast	\$10.00	\$5.75	
Lunch	\$13.00	\$9.50	
Dinner	\$22.00	\$14.00	
<b>Hotels (as accommodation)</b>	Rates negotiated with various hotels	Rates negotiated with various hotels	17-01-09
<b>Room and Board (as accommodation)</b>	Up to \$600.00 per month	\$280.00/month	17-01-09
<b>Transportation</b>	\$0.34/km	\$0.22/km	17-01-09
<b>Witness Fees (hearings)</b>			09-02-04 in the Pre-Bill 99 OPM
Attendance	\$50.00	\$50.00	
Professional	Full day \$600.00 Half day \$300.00	Full day \$333.37 Half day \$166.66	
Non-professional	Full day up to \$110.96 Half day up to \$55.48	Full day \$77.60 Half day \$38.80	

# Facts and figures 2001

Each year, benefits are indexed by the appropriate indexing factor. For 2001:

- the general indexing factor (modified Friedland) is 0.4%, and
- the alternate indexing factor (Consumer Price Index or CPI) is 2.8%.

In the first two columns, you will find the section of the *Act* and the legislated dollar amount under that section. In the third, you will find the indexed amount for 2001. For more information about indexing please refer to 18-01-02, Benefit Dollar Amounts, in the *Operational Policy* manual.

43(2)	The minimum annual amount for full loss of earnings (LOE) is the lesser of <ul style="list-style-type: none"> <li>• \$15,312.51, or</li> <li>• the worker's net average earnings (NAE) before the injury</li> </ul>	\$15,404.50
45(6)	Retirement pension: Benefit paid as a lump sum if it is less than \$1,145.63/year	\$1,152.51
46	Non-economic Loss (NEL) benefit: Base amount = \$51,535.37 Age factor: Plus/minus \$1,145.63 for each year worker is under/over age 45 Maximum amount multiplied by percentage of impairment = \$74,439.52 Minimum amount multiplied by percentage of impairment = \$28,631.22	\$51,844.99 \$1,152.51 \$74,886.75 \$28,803.23
	The benefit is paid as a lump sum if it is \$11,452.07 or less	\$11,520.87
48(2)	Lump sum to surviving spouse: Base amount = \$55,555.55 Age factor: Plus/minus \$1,388.88 for each year spouse is under/over age 40 Maximum lump sum = \$83,333.30 Minimum lump sum = \$27,777.76	\$59,894.02 \$1,497.32 \$89,841.02 \$29,946.99
48(4)	The minimum compensation amount payable for spouse and children = \$15,312.51/year	\$17,004.41
48(8)	If more than one person is entitled to receive periodic and lump sum payments as a spouse <ul style="list-style-type: none"> <li>• the total periodic payment does not exceed 85% of worker's NAE at the time of the injury, and</li> <li>• the total lump sum payment is limited to \$83,333.30</li> </ul>	\$89,841.02
48(13)	Aggregate lump sum payment for children when there is no surviving spouse = \$55,555.55	\$59,894.02
48(22)	Minimum burial or cremation expenses = \$2,083.32	\$2,246.00
54	Maximum earnings ceiling: 175% of the average industrial wage for Ontario for the year in which the accident takes place	\$60,600.00
<b>Pre-1998 Act</b>		
39(1)	The minimum temporary total disability benefit to a worker is <ul style="list-style-type: none"> <li>• \$10,500/year when the NAE are equal to or more than \$10,500, or</li> <li>• the actual NAE if earnings are less than \$10,500/year</li> </ul>	\$15,404.50
50(3)	Maximum clothing allowance: <ul style="list-style-type: none"> <li>• upper limb prosthesis = \$184</li> <li>• lower limb prosthesis/back brace/leg brace = \$368</li> </ul>	\$255.55 \$511.12
147(14)	Additional monthly payment of up to \$200 for workers in receipt of permanent partial disability benefits *(Benefit may be less as it is based on year of initial entitlement)	\$209.54



## Principle 3:

Only when there are exceptional circumstances can decision-makers depart from WSIB policy

### Example from the Benefits Policy Branch

**S**cenario: On March 14, 2000 the WSIB sent a letter to a worker stating that he is entitled to a Non-economic Loss (NEL) benefit in the amount of \$24,500.00. The letter also stated that the benefit will be paid monthly unless, within 35 calendar days, the worker elects to receive it as a lump sum.

On March 16, 2000, before he received the WSIB's letter, the worker finds out that his mother, who lives in Cambodia, has been stricken with a disease from which she is not likely to recover. On March 17, 2000 the worker left for Cambodia and, due to circumstances connected with his mother's illness, was unable to return to Canada until April 25, 2000.

When the worker returned, he found the letter from the WSIB. As the worker did want to elect a lump sum payment, he contacted his NEL clinical specialist.

### Example from the Revenue Policy Branch

**S**cenario: A customer service representative (CSR) initiated a review of an employer's classification on August 1, 2001 and informed the employer in writing. Consequently, August 1, 2001 is the notification date. According to WSIB policy 14-02-06, *Employer Premium Adjustments*, retroactive adjustments are made from the notification date back to the beginning of the calendar year which includes the notification date. During an initial review of the firm's file, it was determined that the employer appeared to be misclassified under an incorrect (lower) construction rate. However, before a final decision could be made, additional information was required about the employer's business activity. The CSR sent out a letter on August 10, 2001 requesting additional information.

The CSR reviewed the employer's file on October 3, 2001 and found that the requested information had not been received. As a result, the CSR sent out a follow-up notice to the employer. The follow-up notice was returned by Canada Post. The CSR was finally able to track the employer down in late November and was informed that the employer had moved to a temporary location for about four months, because they had experienced a major fire in late August. The employer informed the CSR that the WSIB's request was likely destroyed in the fire. The CSR sent the employer a copy of the original request. The employer was unable to deal with the request until 2002, as they had to move back to the original location.

**Q:** Given that the 35-day time limit has expired, could the NEL clinical specialist depart from WSIB policy and award the worker the lump sum payment?

**A:** After confirming the worker's trip to Cambodia through travel evidence, the NEL clinical specialist reviewed WSIB policy 18-05-04, *Calculating NEL Benefits* and determined that the facts of the case came within the policy. The policy states that workers whose NEL benefit is greater than the threshold for that year have 35 calendar days from the date of the decision letter to elect to receive the benefit as a lump sum.

Despite the fact that the workers election to claim a lump sum was not received within 35 calendar days, the NEL clinical specialist concluded that due to the exceptional circumstances, the worker's election to claim his NEL benefit as a lump sum should be honoured.

**Q:** Can the CSR depart from policy 14-02-06, *Employer Premium Adjustments*, and make the classification change to the correct (higher) construction rate, effective as of January 1, 2002?

**A:** Yes. Given that there are exceptional circumstances in this situation, which the CSR was able to verify with the fire department, and since the employer had engaged in contract pricing for 2001 at the lower rate, the CSR decided that it would be unfair to the employer to make the retroactive change effective January 1, 2001. Instead, the CSR decided to make the classification change to the correct (higher) construction rate, effective January 1, 2002.

(cont'd on page 6)

## Principle 3:

Only when there are exceptional circumstances can decision-makers depart from WSIB policy (Cont'd from page 5)

### *Example from the Medical and Occupational Disease Policy Branch*

**S**cenario: A worker with poor kidney function, who must undergo regular intraperitoneal dialysis, continues to work in an occupation with exposure to aluminium dust. While this is harmless to workers with functioning kidneys, who effectively excrete the aluminium, the worker develops neurological symptoms as a result of work exposure. WSIB medical consultants agree that his condition is caused by work exposures in conjunction with his unique predisposition.

WSIB policy 04-03-13, *Occupational Aluminium Exposure, Dementia, Alzheimer's Disease and Other Neurological Effects*, indicates that conditions with neurologic effects are not occupational diseases when they are alleged to result from occupational aluminium exposure.

**Q:** Can the decision-maker depart from WSIB policy 04-03-13, *Occupational Aluminium Exposure, Dementia, Alzheimer's Disease and Other Neurological Effects* and approve the worker's claim for benefits?

**A:** Yes. In this case, the decision-maker may depart from the policy, as there are exceptional circumstances, namely that the worker's pre-existing medical condition made him vulnerable to aluminium dust.

## Coming in future 2001 issues of *Policy Report*



Watch for these timely topics in our 2001 issues of *Policy Report*:

### ***Training participants***

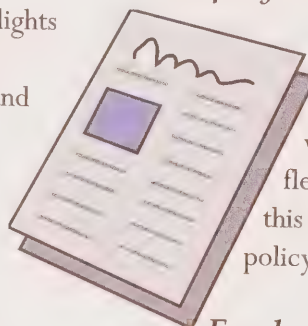
This issue of *Policy Report* will bring you the highlights of policy 12-04-05, *Training Participants*. This policy covers the funding aspects of training programs and describes how a person, company, or training agency can apply for and cancel coverage, and calculate the insurable earnings of a trainee.

### ***You asked us***

This "question and answer" (Q&A) issue will answer frequently-asked questions we have received from our readers.

### ***Employer by application***

Policy 12-01-02, *Employer by Application*, has been revised to give employers, who are not required by law to have WSIB coverage, but who voluntarily apply for coverage, more flexibility in their application options. Look for this issue which will address the changes to this policy.



### ***Employer classification***

We also hope to bring you a special issue that updates *Policy Report Vol. 6 No. 2, Employer Classification - An Overview*.



# 2001 Benefit Rate Changes

## Background

The Workplace Safety and Insurance Board (WSIB) provides workers with various benefits and may pay for a variety of expenses associated with their claims. The rates for some of the benefits and expenses paid by the WSIB are not specifically set in the *Workplace Safety and Insurance Act* (the Act). The WSIB sets and adjusts these rates from time to time.

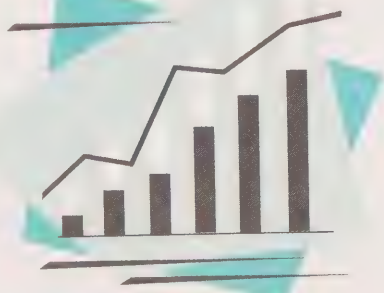
As a result of the review, some of the rates were increased based on information obtained through the external cost findings.”

## Why rates are changing

WSIB staff and external stakeholders expressed concerns that some of these rates were out of date. For instance, the mileage rate, paid to injured workers who must travel to appointments or to other activities associated with their claims, had not been updated for some time and was no longer realistic. There were other rates that had been increased in the recent past but still did not appear to adequately reimburse workers for costs they incurred. In order to clarify what rates were still appropriate and which needed to be changed, the WSIB conducted a full review.

## About the review process

The review intended to determine current costs that might arise in the market place for various items. To identify these costs, the WSIB reviewed what other agencies were paying for expenses and what companies are charging for providing different goods and services. This provided some external cost sampling information. Although the review was not exhaustive, it showed that some rates reasonably covered specific costs and did not require a change at this time, while others were indeed out of date.



## Rate increases

As a result of the review, some of the rates were increased based on information obtained through the external cost findings. A few of the rates had regularly been updated through application of the Consumer Price Index (CPI) changes, and it was determined that a current adjustment based on the 2000 CPI was adequate. Still other rates were not changed at this time because there was no clear indication that they were inappropriate.

The transportation rate was increased from \$0.22/km to \$0.34/km. This was set as a flat rate to reflect market costs, instead of the cascading rate that reduces payments based on greater distances traveled. Fees were increased from \$333.37/day to \$600/day for professional witnesses, and from \$77.60/day to \$110.96/day for lay witnesses to reflect what the courts are currently paying. The room and board allowance was increased from \$280/mth to up to \$600/mth to reflect current market costs (noting regional variations), and expense information obtained through WSIB experience. Meal allowance was increased from \$29.25/day to \$45/day for similar reasons. Also, the maximum burial allowance was increased from \$8,650 to \$10,122 based on actual burial costs submitted during the year 2000. Rates indexed by CPI included allowances for independent living allowance, personal care and guide and support dogs.

“Still other rates were not changed at this time because there was no clear indication that they were inappropriate.”

## Application date

The rates that have been increased apply to all expenses incurred on or after January 1, 2001. For example, the new travel rate applies to travel expenses incurred as of January 1, 2001. Expenses incurred up to December 31, 2000 will still be paid at the “old” rates even though submitted to the WSIB in 2001.

## Table of rates

All of the rates set by the WSIB have been removed from the applicable policies and are now included in a new policy document 18-01-05, *Table of Rates*.

For your reference, this issue of Policy Report includes an insert with *Facts and Figures 2001* on one side and the *2001 Table of Rates* on the other.

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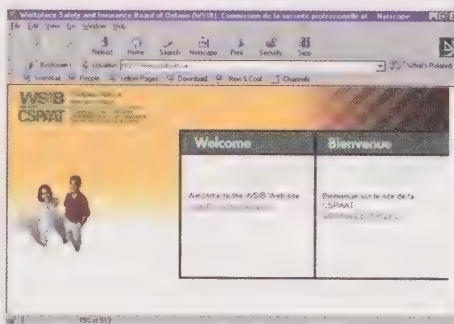
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**WSIB**  
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Workplace Safety &  
Insurance Board

Commission de la sécurité  
professionnelle et de l'assurance  
contre les accidents du travail

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*Policy Report* is published by the Benefits Policy Branch of the Workplace Safety and Insurance Board. If there is any conflict between information in this publication and the *Workplace Safety and Insurance Act* or approved policy documents, the Act or the policy governs.

In this publication, the "old Act" refers to the *Workers' Compensation Act*. The "new Act" refers to the *Workplace Safety and Insurance Act*.

Benefits Policy also publishes the *Operational Policy* manual and the *Employer Classification* manual.

To purchase these publications, or to receive *Policy Report*, please call Policy Publications at (416) 344-4355, or 1-800-387-0750, ext. 4355.

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# POLICY REPORT

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**WSIB**  
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Workplace Safety &  
Insurance Board  
Commission de la sécurité  
professionnelle et de l'assurance  
contre les accidents du travail

Special  
Issue

## The Q&A issue

Policy analysts answer your questions



Every year the WSIB's policy branches—Benefits, Revenue, and Medical and Occupational Disease—receive thousands of inquiries from both internal and external customers and clients. Last year, for example, the Benefits Policy Branch's Policy Analyst On-Call service answered over 3,500 inquiries. These telephone, email, and fax inquiries ranged from general WSIB questions that were unrelated to policy to in-depth issues that required research and analysis.

### The Policy Branches

The WSIB's Policy branches are responsible for the development of policies relating to worker entitlement, classification, occupational disease, and revenue issues. This development includes researching, analysing, and providing advice on policy issues from a legislative, regulatory, social, economic, and public interest perspective.

Once approved, policies are placed in the WSIB's *Operational Policy* and *Employer Classification* manuals and further explained in *Policy Report*. For WSIB staff, policies are placed on the WSIB's internal online database.

### Policy Analyst On-Call

Every day, policy analysts help the WSIB's customers, clients, and internal staff with their policy questions. The policy branches are a resource for all parties. They are not decision-makers. Analysts are careful not to make decisions on behalf of the operating areas nor do analysts contact claims adjudicators to question their decisions. They offer objective policy information, interpretation, and advice.

To help ensure the consistency of the advice given, all calls and their corresponding answers are logged. This allows the policy branches to identify trends in the type of policy issues requiring further clarification. So, in this issue of

*Policy Report* we tackle our customers and clients' most frequently asked questions.

### Need other types of questions answered?

**Appeal inquiries**—(416)344-1014 or toll free, 1-800-387-0773  
**Employer Account inquiries**—(416)344-1004 or toll free, 1-800-387-0080  
**Media Inquiries**—(416)344-4202 or by email [perry\\_jensen@wsib.on.ca](mailto:perry_jensen@wsib.on.ca)  
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**Website question or comments**—(416)344-4192 or toll free, 1-800-387-5540 x4192 or by email [wsibcomm@wsib.on.ca](mailto:wsibcomm@wsib.on.ca)  
**WSIB Library inquiries**—(416)344-4962

### Reaching the Policy Branches

**Benefits Policy**—(416)344-4324 or toll free at 1-800-387-0750 or by email at [bpb@wsib.on.ca](mailto:bpb@wsib.on.ca)

**Revenue Policy**—(416)344-4141

**Medical and Occupational Disease Policy**—(416)344-4365

## Accumulating vacation credits, sick credits, or seniority

**Q** Do vacation credits, sick credits, or seniority continue to accumulate while a worker is off on WSIB insurance benefits?

**A** There is no provision under the *Workplace Safety and Insurance Act* (the Act) for the accumulation of sick credits, vacation credits, or seniority while a worker is off on WSIB insurance benefits.

Under s.25 of the Act, an employer must maintain employment benefit contributions throughout the first year after a worker is injured and is absent from work. These contributions are required if:

- the employer was making contributions at the time of the worker's injury, and
- the worker maintains his or her contribution portion, if any.

Employment benefits, as defined in s.25, are amounts paid wholly or in part by the employer, on behalf of a worker, worker's spouse or same-sex partner, or child/dependant for health care (extended health coverage), life insurance, and pension benefits (this includes payments made into an RRSP). Therefore, vacation credits, sick credits, and seniority are not considered "employment benefits" for the purposes of s.25. Any obligation for the employer to continue the accrual of vacation credits, sick credits, or seniority would be specified in a collective agreement between the employer and the union, or in an employment contract between the employer and the worker.

Any obligation for the employer to continue the accrual of vacation credits, sick credits, or seniority would be specified in a collective agreement between the employer and the union, or in an employment contract between the employer and the worker.

## Worker or independent operator?

**Q** How does a person know if he/she is a worker or an independent operator for Workplace Safety and Insurance purposes?

**A** A worker is employed under a contract of service. This means the employer decides the time, place, and manner in which the work is done. Workers typically provide their labour while the employer provides the worker with the tools, materials, equipment, vehicles, and training necessary to do the job.

A worker receives a T-4 from the employer or employers that he/she works for. Employers make deductions for Income Tax, Employment Insurance, and Canada Pension Plan from the worker's pay. Employers are also responsible for paying premiums to the WSIB on behalf of the worker.

In contrast, an independent operator **runs a business** that does not employ any help. An independent operator is a one-person business that exhibits characteristics such as:

- obtaining work for themselves by advertising the business and the service it provides
- bidding/tendering for work
- making a significant capital investment in the business by owning or providing the tools, equipment, vehicle, and materials necessary to the job
- working for a variety of different employers (i.e., they are not economically dependent upon any one employer).

To be considered an independent operator by the WSIB, the person must first complete an industry specific questionnaire. From this questionnaire the WSIB determines if the person is an independent operator or a worker.

If the WSIB deems the person an independent operator, that person may purchase WSIB optional insurance, private insurance, or choose not to purchase any insurance.

For more information, see 01-02-03, Workers and Independent Operators.



For a copy of an independent operator survey, visit the WSIB website at [www.wsib.on.ca](http://www.wsib.on.ca).



## New claim or recurrence?

**Q** Sometimes, injured workers get hurt a second time and a claim is filed with the WSIB. In some cases, the WSIB decides that a new claim file should be opened. In other cases, the WSIB decides that the claim is, in fact, a recurrence of the existing claim.

What distinguishes a new claim from a recurrence of the existing claim?

**A** The main difference between a new claim and a recurrence is that a new claim must **always** arise out of and be in the course of employment. In contrast, a recurrence may not show up or develop at work and may be due to both work and/or non-work related activities.

Furthermore, the WSIB's policy 15-02-03, Recurrences, states that a recurrence:

- may result from an insignificant new accident, such as reaching for something on a shelf, or
- may arise when there is no new accident (such as a flare-up of the worker's medical condition).

To decide that a claim is a recurrence, the WSIB must either confirm:

- that the worker's current condition is medically compatible to the original work-related accident, or
- a combination of medical compatibility and continuity.

If the WSIB categorizes the claim as a recurrence, any claim costs are charged to the accident employer—the employer who employed the worker at the time of the original accident.

The following chart shows how the distinction between a new claim and a recurrence impacts the rights and obligations of workers and employers.

New Claim	Recurrence
Worker entitled to receive loss of earnings benefits, if appropriate	Loss of earnings benefits only paid if recurrence occurs within 72 months of original accident. If recurrence occurs after 72 months, the worker's loss of earnings benefits, if any, cannot be changed
Average earnings based on earnings at time of injury	Average earnings based on the higher of <ul style="list-style-type: none"><li>• earnings at the time of the original injury (escalated), or</li><li>• most recent earnings</li></ul>
Worker may be entitled to receive labour market re-entry services	Worker may be entitled to receive labour market re-entry services
Worker and accident employer have duty to co-operate in returning the worker to work	Worker and accident employer have continuing duty to co-operate in returning the worker to work
Accident employer obliged to maintain employment benefits for up to one year from date of injury	Accident employer's obligation to maintain employment benefits only lasts for one year from date of original injury
Accident employer's obligation to re-employ lasts for up to two years from date of injury	Accident's employer's obligation to re-employ only lasts for up to two years from date of original injury
Worker entitled to health care	Worker entitled to health care
Worker entitled to NEL benefits, if appropriate	Worker may be entitled to NEL benefits, if appropriate, or a NEL re-determination if the impairment significantly worsens
Accident employer reports all new work-related accidents	If worker still employed with accident employer, employer reports the accident If worker employed with second employer, second employer may report incident as a recurrence If worker not employed, worker reports recurrence

## Entitlement—Accidents in common areas

**Q** Is a worker covered if injured while walking through common areas in order to reach the employer's premises? For example:

- a) multi-employer mall
- b) airport terminal.

**A** Whether a worker is covered in this situation depends on several factors. To determine if an accident is work-related, the WSIB considers any evidence that a worker sustained a personal injury by accident arising out of and in the course of employment. Where the circumstances relating to **place, time, and activity** indicate that the accident was work-related, it generally follows that the accident "arose out of and in the course of employment". (For more information, see 03-01-02, Accident in the Course of Employment.)

The question of coverage for workers in "common areas" relates specifically to the issue of employer premises. An accident occurring on the employer's premises is said to be in the course of employment. Generally, an employer's premises may include:

- the building, plant, or location of work
- entrances, exits, stairs, elevators, and lobbies
- parking lots, passageways, and private roads.

In a multi-storey building or multi-employer building, the employer's premises may include:

- all areas occupied solely by the employer
- all common areas for entering or exiting the building at street level, including outside stairs to public property
- escalators, elevators, stairs to areas occupied by the employer or common areas from a public concourse to the main floor lobby and from the lobby to the floor occupied by the employer.

Workers are generally considered to be in the course of their employment once they enter the employer's premises at the proper time and use an accepted means of entrance. (For more information, see 03-02-02, On/Off Employers' Premises.)

Where an employer is located within a complex consisting of multiple businesses (e.g., plaza, mall, airport terminal, multi-storey building), what constitutes an employer's premises may not be immediately evident. A worker is not in the course of employment while in public parking areas of a plaza, mall, airport terminal, or multi-storey building, which are not under the employer's control. The exception would involve cases where a worker is injured in parking spaces regulated and allocated by the employer.

Similarly, workers on their way to the employer's premises within a plaza, mall, airport terminal, or multi-storey building are generally considered members of the public until they arrive on the employer's premises. Consequently, workers would not be covered for injuries occurring while on indoor streets and walkways open to the general public and not under the employer's control. The exception would involve cases where the worker was injured in one of the accepted common areas listed above. (For more information regarding what constitutes an employer's premises in a multi-employer building, see 03-02-10, Employers' Premises, Parking Lots, Roads, Plazas, Malls, Boundaries.)

Where the circumstances relating to **place, time, and activity** indicate that the accident was work-related, it generally follows that the accident "arose out of and in the course of employment".



A worker is not in the course of employment while in public parking areas of a plaza, mall, airport terminal, or multi-storey building, which are not under the employer's control.

## Entitlement—Normal place of employment

Q Is entitlement/coverage limited to your normal place of employment? For example, would you be covered if you were injured while:

- volunteering on the company's Santa Clause Parade float?
- attending a course paid for by the company?
- performing the duties of a union representative while away from the workplace on union business?

A A personal injury by accident occurs in the course of employment if the surrounding circumstances relating to **place, time, and activity** indicate that the accident is work-related. If a worker with a fixed workplace and fixed working hours is injured while absent from the workplace **on behalf of the employer**, a personal injury by accident generally will have occurred in the course of employment if the factor of **activity** indicates that at the time of the injury the worker was engaged in:

- a work-related activity, or
  - an activity reasonably related to the employment.
- a) If attendance on an employer's Christmas fete is either required, encouraged, or condoned by the employer, and the employer exercises some kind of supervision or control over the float, it may be considered an activity that was reasonably related to the employment and the worker would be covered in the event of an injury.
- b) Where the injury occurs while the worker is attending a course paid for by the employer, the decision-maker must consider all of the surrounding facts and circumstances in an effort to measure to what degree attendance at the course was on behalf of the employer. If this enquiry is viewed as a sliding scale, at one end is "condoned by the employer" at the other end is "required by the employer", and in the middle would be "encouraged by the employer". The closer one comes to "required by the employer", in terms of how strong the employment connection is (such as the nature of the course, would there be any negative consequences to the employee if the course was not taken, and/or is the employer paying for the course), the greater the likelihood that the worker would be considered to be in the course of his/her employment when injured.
- c) For workplace insurance purposes, when a worker engages in union activities it is important to determine whether the company or the union is considered the employer. The WSIB considers union representatives workers of the union if the representatives are:
- paid directly by the union or indirectly with the understanding that the employer is reimbursed by the union
  - engaged, even temporarily, in union business
  - in the control and supervision of the union at the time of injury, and
  - the union made an application for coverage prior to the injury.

If all four conditions are met, the worker is considered a worker of the union for the purposes of WSIB coverage.

Having established the basis for coverage, the decision-maker must still determine if the worker was injured in the course of employment. For all workers, including union members engaged in union business, decision-makers must establish the "work-relatedness" by using the general criteria of time, place, and activity (see the top side-bar).

However, if the union did not apply for and obtain WSIB coverage prior to the injury, the worker would not be covered and is not entitled to WSIB benefits. If the decision-maker determines that an individual is not a worker under the Act and their rights of action/recovery are not taken away by Part I of the Act, that individual may proceed with civil action for damages. For more information see 01-02-03, Workers and Independent Operators.

For more information on accidents in the course of employment, see OPM documents, 03-01-02, Accident in the Course of Employment and 03-02-02, On/Off Employers' Premises.

### Example B

If this enquiry is viewed as a sliding scale, at one end is "condoned by the employer", at the other end is "required by the employer", and in the middle would be "encouraged by the employer".

Condoned by the employer	Encouraged by the employer	Required by the employer
--------------------------------	----------------------------------	--------------------------------

In all cases decision-makers must consider all of the relevant facts and circumstances, and pursuant to s.119(1) of the Act, base their decision on the merits and justice of the case. For more information see, 11-01-03, Merits and Justice.

## Age and WSIB coverage

Q Is there a minimum or maximum age for WSIB coverage?

A No. The Act does not address the question of an age limit for coverage. Under the Act, a worker is entitled to benefits under the insurance plan if the accident arose out of and in the course of employment. A "worker" is defined under s.2(1) of the WSIA in part as "a person who has entered into or is employed under a contract of service or apprenticeship and includes the following:

- a learner
- a student
- an auxiliary member of a police force".

**This is not an exhaustive list. For a complete list see s.2(1) of the Act.**

The fact that the Act does not set a minimum age for entitlement may be related to the fact that when the no fault insurance system was created in 1914, children traditionally worked on the family farm, particularly during the harvest season.

In terms of younger workers, *The Occupational Health and Safety Act* (OHSA) prohibits, by regulation, the employment of children under the age of 14 in an industrial establishment. However, should an employer disregard this regulation and employ a child under the age of 14, that young worker will not be prejudiced under the WSIA because the contract of service is contrary to the OHSA.

Although the Act does not restrict coverage based on age, there can be some impacts of age related to the administration of a claim.

For example, if the worker is less than 16 years of age, WSIB policy requires the worker's parent, guardian, or lawyer, as the case may be, to countersign the consent to the disclosure of functional abilities information. (For more information, see 15-01-03, Workers' Requirement to Claim and Consent.)

The Act does impose some restrictions with respect to the duration of Loss of Earnings (LOE) benefits to older workers. Section 43 states that if the worker is 63 years of age or older at the time of the injury, LOE benefits continue until the earliest of:

- the day the loss of earnings end
- the day the worker is no longer impaired as a result of the injury, or
- two years after the date of injury.

(For more information, see 18-03-04, Older Workers and LOE Benefits.)

As well, the Act generally considers that workers retire at age 65. So, although an injured worker who is older than 65 may be entitled to LOE benefits, entitlement to other benefits, such as LMR services, may be restricted.



To comment on this issue or to submit a policy question please email the Benefits Policy Branch—[www.bpb@wsib.on.ca](http://www.bpb@wsib.on.ca).

# POLICY REPORT

**WSIB** Workplace Safety & Insurance Board  
**CSP/PAAT** Committee on the Development of the Insurance Code of Practice for the Workplace Safety and Insurance Board

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Policy Report is published by the Benefits Policy Branch of the Workplace Safety and Insurance Board. If there is any conflict between information in this publication and the *Workplace Safety and Insurance Act* or approved policy documents, the Act or the policy governs.

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# POLICY REPORT

Vol. 14 No. 4 November 2001

**WSIB** Workplace Safety & Insurance Board  
ONTARIO  
**CSPAAT** Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Clarifying the  
issues

CT 3 12081  
University of Toronto

## Employer's initial accident-reporting obligations revisited

The WSIB revised its "Employers' Initial Accident-Reporting Obligations" policy in March of 2000 (see the original *Policy Report* article in the February 2000 issue). One of the principal changes was to distinguish between the terms **first aid** and **health care**. Since employers are not required to report accidents when workers simply require first aid, these terms were defined to help employers determine when to report a work-related injury. Some customers, however, are experiencing difficulty in the situation when a health care practitioner provides care.

### Care provided by a health care practitioner

The policy defines **first aid** as the one-time treatment given to a worker. It can include:

- the cleaning of minor cuts, scrapes, or scratches
- the treatment of minor burns
- the application of bandages, dressing, splints, etc., and
- any follow-up visits made for **observation purposes** only.

The policy also defines **health care** to include:

- services requiring the professional skills of a health care practitioner
- services provided by or at hospitals or health facilities, and
- prescriptions drugs.

Because first aid is care that can be provided by a layperson, the question arises as to whether employers should always complete an accident report form when a worker is cared for by a health care practitioner.

The policy assumes that workers who require first aid generally seek care from a **first-aider**. Consequently, the worker's decision to seek care from a health care practitioner, as opposed to a first-aider, should generally be seen as a need for health care.

However, the policy does allow for the possibility of health care practitioners providing first aid only.

This possibility is more likely to occur:

- at hospitals or health facilities that are **workplaces**. That is, health care practitioners who work at hospitals or health facilities may be called upon to provide co-workers with first aid only
- with employers who have on-site health care practitioners, and
- at health care facilities that have contracts with specific employers to provide first aid and health care to their workers.

Therefore, apart from these exceptions, employers can presume that if a health care practitioner provides care to a worker, that worker received health care **unless** it is clear that the worker only received first aid.

### In practical terms

How can an employer conclude that a worker only received first aid from a health care practitioner? Generally, an employer may draw this conclusion if the facts demonstrate that:

- the **professional skills** of the health care practitioner were not used, and
- a first-aider could have provided the care.

For example, if the facts demonstrate that the health care practitioner simply applied a dressing to the injury and did not provide a clinical assessment, the employer can conclude that the professional skills of the health care practitioner were not used and that a first-aider could have provided the care. In this situation the employer would not have an obligation to report.

## Employer's initial accident-reporting obligations revisited

*continued from page 1*

In contrast, if the facts demonstrate that a health care practitioner conducted a clinical assessment, the employer should conclude that the professional skills of the health care practitioner were used. The fact that the professional skills were used would render this situation health care and would trigger the employer's obligation to report. It does not matter if following the clinical assessment that a simple bandage was applied, or no actual treatment was required.

Therefore, **regardless** of whether the care was provided:

- on the employer's premises,
- at the health care practitioner's office, or
- at a hospital or health facility,

the issue of whether professional skills were required must be answered to determine if the employer needs to complete a Form 7.

If customers remain unclear as to whether a reporting obligation exists in particular cases, they should call their WSIB contact.

## Did you know...



...that the WSIB suggests that employers retain all WSIB-related documents for the:

- current year, and
- previous six calendar years?

This is a general guideline all employers may use for the retention of WSIB records.

This guideline applies to the Ontario WSIB only and cannot be applied, either expressly or implicitly, to any other branch of government (federal, provincial, or municipal) that requires individual persons or corporations to store records or documents.

...that a health professional is a member of a college of a health profession as defined in the Regulated Health Professions Act, 1991 (RHPA).

Health professionals include, but are not limited to:

- physicians and surgeons, and other medical specialists
- chiropractors
- dentists, oral surgeons, and periodontists
- registered nurses, midwives, and nurse practitioners
- physiotherapists, or
- occupational therapists and speech therapists?

For more information see s.2(1) of the WSIA.

...that the WSIA defines health care practitioners as:

- any health professional (as defined in the RHPA)
- a drugless practitioner regulated under the *Drugless Practitioners Act*, i.e., naturopath, or
- a social worker?

# POLICY REPORT

**WSIB**  
ONTARIO  
**CSPAAT**

Workplace Safety &  
Insurance Board

Commission de la sécurité  
professionnelle et de l'assurance  
contre les accidents du travail

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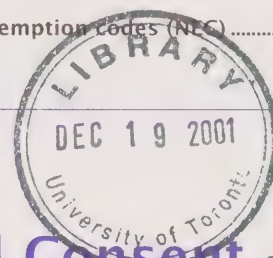
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# POLICY REPORT

Vol. 14 No. 5 December 2001

**WSIB** Workplace Safety & Insurance Board  
**ONTARIO**  
**CSPAAT** Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

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## Two revised policies

# Workers' Requirement to Claim and Consent and Survivors' Requirement to Claim for Benefits

Questions raised by external clients prompted the WSIB's Benefits Policy Branch to review and revise two policies in the *Operational Policy* manual (OPM) clarifying section 22 of the *Workplace Safety and Insurance Act* (WSIA):

- 15-01-03, *Workers' Requirement to Claim and Consent*, and
- 15-01-04, *Survivors' Requirement to Claim for Benefits*.

External clients asked:

- Should the policies apply to claims with accidents occurring before January 1, 1998?
- Are the criteria for extending the six-month time limit to claim for benefits and consent to the disclosure of functional abilities information too restrictive?
- Can decisions about whether the requirements are met be appealed through the WSIB's internal and external appeal process?

Following a review of these issues, the policies were changed as described in this article.

## Claim and consent issues are subject to appeal

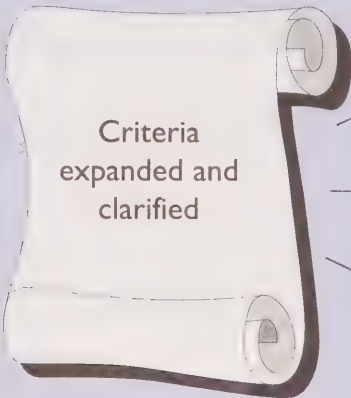
Although the revised policies do not state that a worker/survivor can appeal a WSIB decision denying entitlement because the six-month time limit to claim or consent was not met, any past decisions made in accordance with the old policies are subject to the internal and external appeal process. Therefore, all pre-1998 and post-1998 claims that were or are denied entitlement because they did not meet the claim and/or consent requirements are subject to the WSIB's **internal** and **external** appeal process. For example, if a claims adjudicator initially denied a claim, the worker or the worker's representative can ask the claims adjudicator to reconsider the decision. If the claims adjudicator does not change the decision, the objection to the decision can be referred to the WSIB's Appeals Branch. If the Appeals Branch also denies entitlement, the further objection can be referred to the Workplace Safety and Insurance Appeals Tribunal (WSIAT).

A decision is still subject to appeal, even if:

- the worker was previously informed by the WSIB in writing that the matter was not subject to appeal, and/or
- the worker was not informed and/or did not meet the time limit to appeal this decision.

(continued on page 2, see Claim and consent issues are subject to appeal)

# Changes to 15-01-03, Workers' Requirement to Claim and Consent

Wording in previous policy	Wording in revised policy
<p style="text-align: center;"><b>Application date</b></p> <p>Policy applies to all claims for benefits filed on or after January 1, 1998.</p>	<p>Policy applies to all claims <b>with accidents that occur</b> on or after January 1, 1998.</p>
<p><b>Criteria for extending the six-month time limit to claim/consent have been expanded and clarified</b></p> <div style="display: flex; align-items: center;"> <div style="flex: 1;"> <ul style="list-style-type: none"> <li>• unexpected illness, accident, or</li> <li>• compelling personal reasons, such as a death in the family.</li> </ul> </div> <div style="flex: 1; text-align: center;">  <p><b>Criteria expanded and clarified</b></p> </div> <div style="flex: 2;"> <ul style="list-style-type: none"> <li>• compelling personal reasons, such as serious health problems or accident (experienced by the party or the party's immediate family), or the party leaving the province/country due to the ill health or death of a family member</li> <li>• the worker's ability to understand the time limit requirements and consequences of not meeting them (e.g., was the worker made aware at the workplace of the requirement to claim and consent; were language difficulties a factor), and</li> <li>• whether the worker reported the accident to the employer, health care professional, or co-workers.</li> </ul> <p><b>Note:</b> The revised criteria are meant to help decision-makers determine the circumstances under which they can extend the six-month time frame in which a worker can:</p> <ul style="list-style-type: none"> <li>• file a claim for benefits, and</li> <li>• consent to the release of functional abilities information.</li> </ul> </div> </div>	

## Claim and consent issues are subject to appeal (cont'd from page 1)


### New process for reviewing claims referred to WSIAT

Currently, the WSIB and WSIAT are setting up a process for sending back to the WSIB claims in which appeals were filed with the WSIAT because of unfavourable WSIB decisions regarding workers' /survivors' requirement to claim and consent. This new process will require that:

1. Each claims adjudicator reconsider these particular claims.
2. If the claims adjudicator's review does not change the existing decision, the matter will be directed to the Appeals Branch for further review.
3. If the interested party is not satisfied with the Appeal Branch's decision, the matter can be referred to the WSIAT.



# Changes to 15-01-04, Survivors' Requirement to Claim for Benefits

Wording in previous policy	Wording in revised policy
<b>Application date</b>	
Policy applies to all claims for benefits filed on or after January 1, 1998.	Policy applies to all claims <b>with accidents that occur</b> on or after January 1, 1998. Portions of the policy referring to same-sex partners apply to all claims filed on or after March 1, 2000.
<b>Criteria for extending the six-month time limit to claim for benefits have been expanded</b>	
<ul style="list-style-type: none"><li>when entitlement for the work-related death was established, the WSIB was not aware of the survivor</li><li>when the worker died, the survivor was unaware of his/her rights under the WSIB's insurance plan, e.g., when a worker dies of a heart attack at work and the employer does not submit an accident report to the WSIB</li><li>the survivor did not learn that the death was work-related until long after the worker's death. This is especially common in occupational disease cases.</li></ul>	<div><div>Same</div><div>→</div><ul style="list-style-type: none"><li>when entitlement for the work-related death was established, the WSIB was not aware of the survivor</li></ul></div> <div><div>Same</div><div>→</div><ul style="list-style-type: none"><li>when the worker died, the survivor was unaware of his/her rights under the WSIB's insurance plan, e.g., when a worker dies of a heart attack at work and the employer does not submit an accident report to the WSIB</li></ul></div> <div><div>Same</div><div>→</div><ul style="list-style-type: none"><li>the survivor did not learn that the death was work-related until long after the worker's death. This is especially common in occupational disease cases</li></ul></div> <div><ul style="list-style-type: none"><li>the survivor was unable to understand the time limit requirements and the consequences of not meeting them (e.g., were language difficulties a factor)</li><li>compelling personal reasons, such as serious health problems or accident (experienced by the party or the party's immediate family) or the party having to leave the province/country due to ill health or death of a family member.</li></ul></div>
<b>Note:</b> The new criteria are meant to help decision-makers determine the circumstances under which they can extend the six-month time frame in which a survivor can file a claim for benefits.	

?????????

## If you have questions about...

**These revised policies:**  
Contact Jerry Verhovsek, Policy Analyst, Benefits Policy Branch at (416) 344-4346, or toll-free at 1-800-387-5540 Ext. 4346, or via e-mail at [jerry\\_verhovsek@wsib.on.ca](mailto:jerry_verhovsek@wsib.on.ca)

**The implementation of these policies:**  
Contact Paul Gilkinson, Manager, Appeals Branch at (416) 344-3551, or toll-free at 1-800-387-5540 Ext. 3551, or via e-mail at [paul\\_gilkinson@wsib.on.ca](mailto:paul_gilkinson@wsib.on.ca)

# Examples of Claim/Consent Issues

## Example 1 — Accident Date of June 1997

On June 12, 1997, Sheila experienced a low back strain at work. As a result, she was off work for three weeks and chose to receive vacation pay. She got medical attention but did not tell her doctor that the injury had resulted from her employment. Neither Sheila nor her employer reported the accident to the WSIB. Although she went back to work in early July 1997, she experienced ongoing low back symptoms that became worse in March 1998, when she had to take time off work again. She then claimed for WSIB benefits for the initial period of June-July 1997 and for her recurrence. However, the Claims Adjudicator denied her claim because she did not claim within six months from the date of her accident on June 12, 1997.

### Which legislation applies?

This accident/injury is governed by the *Workers' Compensation Act* (WCA). Section 22 of the WCA provides direction regarding the requirement to claim for benefits within six months of an accident/injury and states:

“Failure to give the prescribed notice or to make such claim or any defect or inaccuracy in a notice does not bar the right to compensation if in the opinion of the Board the employer was not prejudiced thereby or, where the compensation is payable out of the accident fund, if the Board is of the opinion that the claim for compensation is a just one and ought to be allowed.”

### Which policy applies?

Because this worker's injury took place before January 1, 1998, which is the application date of the revised policy 15-01-03, *Workers' Requirement to Claim and Consent*, the revised policy does not apply to this particular claim. For accidents occurring before January 1, 1998, there is no specific WSIB policy that deals with the worker's time limit to claim.

Before 1998, the factor that determined whether a claim, filed past the six-month time limit was allowed or denied, was whether there was enough information for the WSIB to make a proper investigation and consequently a fair ruling. For a proper WSIB investigation to take place, a claim must have five points known as the “five point check system” (see

02-01-02, *Adjudicative Process*):

“All adjudicators use the same criteria for ruling on initial entitlement to WCB benefits. This system is known as the ‘five point check system’. An allowable claim must have the following five points:

- an employer (see 08-01-01, *Who is an Employer?*)
- a worker (see 01-02-03, *Workers and Independent Operators*)
- personal work-related injury (see 03-01-02, *Accident in the Course of Employment*)
- proof of accident, and
- compatibility of diagnosis to accident or disablement history.”

**Note:** Prior to January 1, 1998, there was no legislative or policy requirement that the worker consent to the disclosure of functional abilities information.

“An allowable claim must have the following five points:

- an employer
- a worker
- personal work-related injury
- proof of accident, and
- compatibility of diagnosis to accident or disablement history.”

Policy 02-01-02, *Adjudicative Process*

### Can this decision be appealed?

All pre-1998 and post-1998 claims that were or are denied entitlement because they did not meet the claim and/or consent requirements are subject to the WSIB's internal and external appeal process. In this example, although the Claims Adjudicator initially denied the claim, the worker or the worker's representative can ask the Claims Adjudicator to reconsider the decision. If the Claims Adjudicator does not change the decision, the objection to the decision can be referred to the WSIB's Appeals Branch. If the Appeals Branch also denies entitlement, the objection can be referred to the WSIAT.

(continued on page 5)



# Examples of Claim/Consent Issues (cont'd from page 4)

## Example 2 — Accident Date of September 1998

In September of 1998, Albert slipped at work and twisted his ankle. Although Albert told his supervisor and his co-workers about his injury, he was not told by his supervisor or his co-workers that he was required to claim and consent. He got medical attention but did not tell his physician that the injury had happened at his workplace. Consequently, neither the worker, nor the employer, nor the physician submitted a report of the accident. Initially, Albert did not lose any time from work. However, his ankle symptoms persisted. In July 1999, he again saw his physician who told him to remain off work for several weeks and begin active treatment. At that time, the worker, physician, and employer submitted their reports to the WSIB. However, the Claims Adjudicator denied the claim because Albert did not claim within six months of the date of his accident in September 1998.

### Which legislation applies?

The Claims Adjudicator has to decide whether or not to extend Albert's time limit to claim and consent. Because this accident occurred after January 1, 1998, it is governed by the *Workplace Safety and Insurance Act* (WSIA). In the WSIA, s.22 states that while the worker is required to claim and

consent within six months of the accident, this time limit may be extended "if, in the opinion of the Board, it is just to do so".

### Which policy applies?

The circumstances under which the time limit to claim and consent can be extended are outlined in the **revised** policy 15-01-03, *Workers' Requirement to Claim and Consent*. Thus, the Claims Adjudicator must review Albert's claim in light of the criteria in this **revised** policy in order to determine whether he understood the claim and consent requirements and/or had any compelling personal reasons for not meeting the requirements (the criteria in the revised policy is listed on page 2).

### Can this decision be appealed?

In this example, although the Claims Adjudicator initially denied the claim, Albert or Albert's representative can ask the Claims Adjudicator to reconsider the decision. If the Claims Adjudicator does not change the decision, the objection to the decision can be referred to the WSIB Appeals Branch. If the Appeals Branch also denies entitlement, the further objection can be referred to the WSIAT.

## Forms workers need to sign or complete to claim for WSIB benefits

As soon as possible after an accident or work-related illness, or within six months of the accident or, in the case of an occupational disease, after the worker learns that he or she suffers from the disease, the worker must:

- **file a claim** for benefits, and
- **consent to disclose his/her functional abilities information**, which is provided by the treating health professional on the Functional Abilities Form for Timely Return to Work (see 19-02-04).

Depending on the circumstances, the worker can use a number of different forms to claim and consent. Many forms are available on the WSIB web site (at [www.wsib.on.ca](http://www.wsib.on.ca)). They can be printed and then completed manually, or completed online and then printed. The table on following two pages describes when the worker would use a particular form, the person(s) responsible for completing it, completion time frames, consequences of not completing the form, as well as

where to get the form, and who gets a copy of the completed form.

(continued on page 6)

WSIB CSPAT		Worker's Claim/Consent Form Demande de prestations et consentement du travailleur	
DO NOT RETURN THIS TO THE WSIB. NE PAS RETOURNER LE PRÉSENT FORMULAIRE À LA CSPAT.			
<b>Worker's Signature</b> By signing below, I am claiming benefits under the Workplace Safety and Insurance Act, 1997, for a work-related injury or disease. I am also authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board with information about my functional abilities on the Board's "Functional Abilities for Timely Return to Work" form.		<b>Signature du travailleur</b> En signant ci-dessous, je réclame des prestations en vertu de la Loi de 1997 sur la sécurité professionnelle et l'assurance contre les accidents du travail, pour une lésion ou une maladie reliée au travail. De plus, j'autorise tout professionnel de la santé qui me traite à remettre à mon employeur, à la Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail et à moi une copie du formulaire intitulé <i>Détermination des capacités fonctionnelles pour un retour au travail rapide</i> , sur lequel il aura fourni les renseignements sur mes capacités fonctionnelles.	
Print Name (in full)		Prénoms et nom de famille (en caractères d'imprimerie)	
Signature		Signature	
Date signed		Date de la signature	
Accident Date		Date de l'accident	
Description of Injury/Disease		Description de la lésion	
Employee ID / SIN		Identification de l'employé / NAS	
Employer FAX Number		Numéro de télécopieur de l'employeur	
<small>Employer Instructions: Use this form when you cannot get your employee's signature on the Form 7. Keep your copy on file. Send the white copy to the worker's health professional as permission from the worker to release functional abilities information. If required, to help with a safe return to work plan. Message à l'employeur: Veuillez utiliser ce formulaire lorsque vous êtes incapables d'obtenir la signature de votre employé sur le Formulaire 7. Conservez votre copie dans vos dossiers et envoyez le copie blanche au professionnel de la santé. Par l'entremise du présent formulaire, le travailleur autorise le professionnel de la santé à divulguer les renseignements portant sur ses capacités fonctionnelles, si besoin est, afin d'aider les parties à élaborer un programme de retour au travail sécuritaire.</small>			
1482C (10/98)		White Copy - Health Professional Copie blanche - Professionnel de la santé	
		Grey Copy - Employer Copie grise - Employeur	
		Pink Copy - Worker Copie rose - Travailleur	

## Forms workers need to sign or complete to claim for WSIB benefits (cont'd)

	Form 7 Employer's Report of Injury/Disease	Form 1492 Worker's Claim/ Consent Form	Form 6 Worker's Report of Injury/Disease	Form REO6 Worker's Continuity Report
<b>When does the worker sign/complete the form?</b>	<p>After the employer completes the Form 7, the worker completes the section dealing with the claim for benefits and the consent to the disclosure of functional abilities information.</p> <p><b>Note:</b> The worker's signature on the Form 7 does not necessarily mean that the worker agrees with what the employer has reported on it. A worker may always submit further information to the WSIB.</p>	<p>If, for any reason, the worker does not sign the Form 7 in order to claim and consent, the worker can use Form 1492 to do so.</p>	<p>The WSIB sends a Form 6 to the worker to complete, if the WSIB receives:</p> <ul style="list-style-type: none"> <li>• a Form 7, either without the worker's signature or with an indication that the worker has not signed a Form 1492</li> <li>• a Form 7 that has insufficient information to determine entitlement to benefits</li> <li>• a Form 8 from the worker's treating health professional but not a Form 7 from the employer (see 17-02-02, <i>Health Care Practitioner's Reports</i>), or</li> <li>• a request from the worker to initiate a claim (a worker can use a Form 6 to initiate a claim independently).</li> </ul>	<p>If a worker has a recurrence of a work-related injury or disease between six months and three years of the last return-to-work date, the worker must complete a Form REO6, the Worker's Continuity Report.</p> <p>Form REO6 also requires the worker to consent to the disclosure of his/her functional abilities information.</p>
<b>Timeframe for completing the form</b>	<p>Because the WSIB must receive an employer's complete accident report <b>within seven business days of the employer learning of the reporting obligation</b>, a worker who uses a Form 7 to meet the requirement to claim and consent must be mindful of this time requirement. See 15-01-02, <i>Employers' Initial Accident-Reporting Obligations</i>.</p>	<p>As soon as possible after an accident or work-related illness, or within six months of the accident or, in the case of an occupational disease, after the worker learns that he or she suffers from the disease.</p>	<p>As soon as possible after an accident or work-related illness, or within six months of the accident or, in the case of an occupational disease, after the worker learns that he or she suffers from the disease.</p>	<p>If the WSIB sends the worker a Form REO6 to complete</p> <ul style="list-style-type: none"> <li>• before the six-month deadline has expired, the worker has the balance of the six months, or thirty calendar days, whichever is greater, to return it to the WSIB.</li> <li>• after the six-month deadline has expired, the worker is given thirty calendar days to return it to the WSIB.</li> </ul>



## Forms workers need to sign or complete to claim for WSIB benefits (cont'd)

	<b>Form 7 Employer's Report of Injury/Disease</b>	<b>Form 1492 Worker's Claim/ Consent Form</b>	<b>Form 6 Worker's Report of Injury/Disease</b>	<b>Form RE06 Worker's Continuity Report</b>
<b>Consequences of not completing the form</b>	A worker who is entitled to benefits under the insurance plan, receives one initial benefit payment from the WSIB — up to two weeks of loss of earnings (LOE) benefits. After that, until the worker meets the requirements to claim and consent (by signing/ completing a Form 7, a Form 1492, or a Form 6), the worker cannot receive any further WSIB benefits.	A worker who is entitled to benefits under the insurance plan, receives one initial benefit payment from the WSIB — up to two weeks of LOE benefits. After that, until the worker meets the requirements to claim and consent (by signing/ completing a Form 7, a Form 1492, or a Form 6), the worker cannot receive any further WSIB benefits.	A worker who is entitled to benefits under the insurance plan, receives one initial benefit payment from the WSIB — up to two weeks of LOE benefits. After that, until the worker meets the requirements to claim and consent (by signing/ completing a Form 7, a Form 1492, or a Form 6), the worker cannot receive any further WSIB benefits.	A worker may not receive <b>any</b> WSIB benefits for a recurrence of a work-related injury or disease unless the worker provides a completed Form RE06 to the WSIB.
<b>Where/how to get the form</b>	<ul style="list-style-type: none"> <li>Employers should have a supply of Form 7s</li> <li>the WSIB web site at <a href="http://www.wsib.on.ca">www.wsib.on.ca</a></li> <li>the WSIB order desk at (416) 344-3862 or 1-800-387-0750</li> <li>all Ontario WSIB offices, see 99-02-02, <i>Ontario WSIB Offices</i>.</li> </ul>	<ul style="list-style-type: none"> <li>Employers should have a supply of Form 1492s</li> <li>the WSIB web site at <a href="http://www.wsib.on.ca">www.wsib.on.ca</a></li> <li>the WSIB order desk at (416) 344-3862 or 1-800-387-0750</li> <li>all Ontario WSIB offices, see 99-02-02, <i>Ontario WSIB Offices</i>.</li> </ul>	<ul style="list-style-type: none"> <li>Claims adjudicators send Form 6 to a worker, when an injury is reported to the WSIB</li> <li>the WSIB web site at <a href="http://www.wsib.on.ca">www.wsib.on.ca</a></li> <li>the WSIB order desk at (416) 344-3862 or 1-800-387-0750</li> <li>all Ontario WSIB offices, see 99-02-02, <i>Ontario WSIB Offices</i>.</li> </ul>	<ul style="list-style-type: none"> <li>Claims adjudicators send Form RE06 to a worker, when a recurrence of an injury is reported to the WSIB</li> <li>the WSIB order desk at (416) 344-3862 or 1-800-387-0750</li> <li>all Ontario WSIB offices, see 99-02-02, <i>Ontario WSIB Offices</i>.</li> </ul>
<b>Who gets a copy of the completed form</b>	<ul style="list-style-type: none"> <li>the WSIB</li> <li>employer</li> <li>worker</li> </ul>	<ul style="list-style-type: none"> <li>employer</li> <li>worker</li> <li>worker's treating health professional</li> </ul>	<ul style="list-style-type: none"> <li>the WSIB</li> <li>employer</li> <li>worker</li> </ul>	<ul style="list-style-type: none"> <li>the WSIB</li> <li>employer</li> <li>worker</li> </ul>

# Season's Greetings!

*Wishing you peace, love and happiness in the New Year.  
from the Policy and  
Research Division*

## Survivors need to complete Form 3197A to claim for WSIB benefits

A survivor, who is entitled to benefits as a result of a worker's death, must:

- file a claim (using Form 3197A, Dependency Claim) within six months of the worker's death, and
- give a copy of the claim for benefits to the worker's employer or, in the case of occupational diseases, to the employer who most recently employed the worker in the employment to which the disease is associated. In WSIB terms, this is referred to as "the survivors' requirement to claim".

For more information about survivor benefits:

- see policy 15-01-04, *Survivors' Requirement to Claim for Benefits*, and policies 20-01-02 through 20-03-15
- phone the WSIB's Occupational Disease and Survivor Benefits Program at (416) 344-1010 or 1-800-465-9646, or
- read the information on the WSIB's web site (instructions for accessing the information on the web site follow).

## Employers Now Required to Submit Two Net Exemption Codes

Starting January 1, 2002, the WSIB will request **two** net exception codes or claim codes from employers who report earnings information. Until recently, provincial income tax was calculated as a percentage of federal income tax. Therefore, only one exemption code was required to calculate the amount of income tax that must be withheld by an employer.

On January 1, 2001, Canada Customs and Revenue Agency (CCRA—formerly Revenue Canada) introduced the TONI (tax on income) system which allows provinces to calculate taxes based on income. Both the federal and provincial governments now set their own exemption codes. As a result, when reporting a worker's earnings employers must now submit both the provincial and federal exemption codes.

Under s.55(1) of the WSIA, the WSIB determines the amount of a worker's net average earnings (NAE) by deducting from his or her earnings the probable:

- income tax
- Canada Pension Plan (CPP) or Quebec Pension Plan (QPP) premiums, and
- employment insurance (EI) premiums payable by the worker.

The WSIB calculates the worker's "probable income tax" payable by using the worker's net exemption code (NEC) that the worker files with the employer. The employer indicates the code on the Form 7 when reporting accidents to the WSIB.

To comply with the new legal requirement to determine the "probable income tax payable", the WSIB modified its computer systems allowing for the separate calculation of federal and provincial income taxes. There will, however, be no fundamental change to the way benefits are calculated.

# POLICY REPORT

**WSIB**  
ONTARIO  
**CSPAAT**

Workplace Safety & Insurance Board  
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

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# POLICY REPORT

Vol. 15 No. 1 Feb. 2002

## Changes to TB Schedule 3 entry and the TB Policy

Legislative Cabinet, following the recommendations of the Occupational Disease Panel and the WSIB, amended Schedule 3 of the Act. Because of changes to the Schedule 3 entry for Tuberculosis (TB), the TB policy has been updated. These changes reflect how our understanding of the incidence, spread, control, and prevention of TB has changed in the past decade.



### What is TB?

TB is a disease caused by a bacterial infection of *tubercle bacilli*. The most common form is pulmonary tuberculosis, where the infection occurs in the lungs. When first infected with TB, a person's immune system may eliminate the bacteria or the bacteria may be sealed within scar tissue where it can remain dormant for years. This first infection usually has no symptoms.

Later, the bacteria may break through the scar tissue, usually when the person's immune system has been compromised. Usually, this infection is more severe than the initial infection because the bacteria have established a breeding colony in the body and the person's immune system is not fully functioning. Any, all, or none of the following symptoms may appear:

- a cough that will not go away
- feeling tired all the time
- weight loss
- loss of appetite
- fever
- coughing up blood.

Tuberculosis is spread through inhaling TB positive sputum, mucous-like material coughed up from the respiratory system (pulmonary TB). TB can also be found in animals, and these animals can also pass TB to humans. Brief exposure to a source of TB rarely infects a person; close contact over a long period of time is the usual cause of TB infection.

The exception to this rule are people with already compromised immune systems, such as HIV infections, that can be infected with brief exposure.

If a doctor thinks that a patient might be infected with TB, a Tuberculin skin test is performed. A positive test means the person had been in contact with TB bacteria. X-rays would determine if the bacteria had done any harm.

### Treatment

In 1944 Dr. Waksman found an antibiotic substance, which he named streptomycin, that kills the tubercle bacillus.



Dr. Waksman (right) with Dr. Fleming another pioneer of antibiotic research

Unfortunately, there is no quick cure for TB. The *tubercle bacilli* are sealed behind a layer of scar tissue, called a tubercle, that is not easily penetrated by

drugs. Long-term drug treatment, usually lasting six to eight months, is needed to allow the drugs time to seep into the tubercles.

## Revised policy

# Tuberculosis, 16-01-03

## Workers covered

Previously, the *Tuberculosis* policy (04-02-06 in the pre-Bill 99 OPM) specifically covered workers in the medical and healthcare fields. Workers in other fields may have been covered based on the individual merits of the case.

Now to better recognize the fact that workers in other fields can be routinely exposed to TB, the new policy extends coverage to workers if they are routinely exposed during the course of their employment to an established source of tuberculosis infection or to the *tubercle bacilli*.

Example: Coverage can include workers dealing with immigrants and foreign visitors. Because of the prevalence of TB in much of the world (see **The changing understanding of TB** on page 3) workers who deal with immigrants and foreign visitors can be routinely exposed.

## Types of TB covered

There are many different types of TB. The most common is pulmonary TB, but TB can infect almost any area of the body (extra-pulmonary). Other parts of the body that are particularly susceptible include the bones and joints, and the lymphatic, reproductive, urinary, and digestive systems.

Since extra-pulmonary TB infects people in a similar manner as pulmonary TB, it is now explicitly included in the new policy.

## Recurrences

The WSIB considers any recurrence of TB within three years of the worker's recovery and return to work under the original claim, whether or not the worker returns to the job with exposure to TB. If a recurrence occurs after three years, it is adjudicated as a new claim because, if the worker followed the proper course of treatment, the initial case of TB should have been cured within that time. Therefore, this case may be a new infection and not necessarily a recurrence.

## Presumption of Entitlement

Entitlement to benefits is decided on the clinical evidence of TB, along with the likelihood of TB exposure in the course of work. The presumption is that the claim is work-related.

A rebuttal of a presumption occurs if:

- the worker is no longer employed in a job with exposure to TB **and** the evidence of active TB occurs after six months of the exposure employment.
- the worker has a prior history of TB within the last three years. This claim would be considered a re-activation of the prior condition.

## Example

Ms. Greene developed TB symptoms and tested positive for TB nine months after leaving the employment of BFK Ltd., where Ms. Greene regularly encountered people with TB. The presumption of entitlement would be rebutted for two reasons:

1. The worker is no longer employed in a job with exposure to TB.
2. The evidence of TB occurred more than six months after leaving BFK Ltd.

**Ms. Greene's claim would then be adjudicated on its own merits.**

In order for the WSIB to obtain the necessary information to adjudicate the claim:

- the worker must complete and return to the WSIB the "Worker's Report of Tuberculosis" Form 0084A, and
- the employer must complete and return to the WSIB the "Employer's Report of Tuberculosis" Form 0255A, with the physician completing the medical report.

## Laboratory and Specimen Collection Centre Licensing Act R.S.O. 1990

A laboratory is now defined using the following definition from the above Act:

"laboratory" means an institution, building, or place in which operations and procedures for the microbiological, serological, chemical, hematological, biophysical, immunohematological, cytological or pathological examination of specimens taken from the human body are performed to obtain information for diagnosis, prophylaxis or treatment, but not including simple procedures prescribed by the regulations that are carried out by legally qualified medical practitioners exclusively for the purpose of the diagnosis and treatment of their patients.



# 2002 Table of Rates

Every year, the WSIB reviews and sets the following rates after conducting an external survey of costs for each specific rate. The only exception is the minimum burial rate. This rate is indexed annually according to the alternate-indexing factor, the Consumer Price Index (CPI).

The rates apply as of January 1, 2002.

For more information on the rates please refer to the policy documents referenced in the table.

Benefit	Last year's rate	Rate in 2002	OP Document
<b>Independent Living Allowance</b>	\$2,974.05/yr	\$3,030.55/yr	17-06-02
<b>Personal Care Allowance</b>			17-06-05
General Attendant Rate*	\$6.85/hr	\$6.85/hr	
Personal Attendant Rate	\$10.01/hr	\$10.20/hr	
Skilled Attendant Rate	\$16.04/hr	\$16.34/hr	
Bookkeeping Fee	\$720.00 annually	\$720.00 annually	
*set at minimum wage			
<b>Clothing Allowance</b>	min. damage \$255.55 max. maj. damage \$511.12 max.	min. damage \$255.55max. maj. damage \$511.12 max.	17-05-02
<b>Escorts</b>	\$51.00 /day	\$54.80/day	17-01-08
<b>Burial Expenses</b>	\$2,246.00 minimum \$10,122.00 maximum	\$2,288.70 minimum \$11,197.10 maximum	18-01-05 20-03-02
<b>Guide and Support Dog Allowance</b>	\$805.63 annually	\$820.93 annually	17-06-04
<b>Meal Allowance</b>			17-01-09
Breakfast	\$10.00	\$10.00	
Lunch	\$13.00	\$13.00	
Dinner	\$22.00	\$22.00	
<b>Hotels (as accommodation)</b>	Rates negotiated with various hotels	Rates negotiated with various hotels	17-01-09
<b>Room and Board (as accommodation)</b>	Up to \$600.00 per month	Up to \$600.00 per month	17-01-09
<b>Transportation</b>	\$0.34/km	\$0.34/km	17-01-09
<b>Witness Fees (hearings)</b>			09-02-04 in the Pre-Bill 99 OPM
Attendance	\$50.00	\$50.00	
Professional	Full day \$600.00 Half day \$300.00	Full day \$600.00 Half day \$300.00	
Non-professional	Full day up to \$110.96 Half day up to \$55.48	Full day up to \$110.96 Half day up to \$55.48	

# Facts and figures 2002

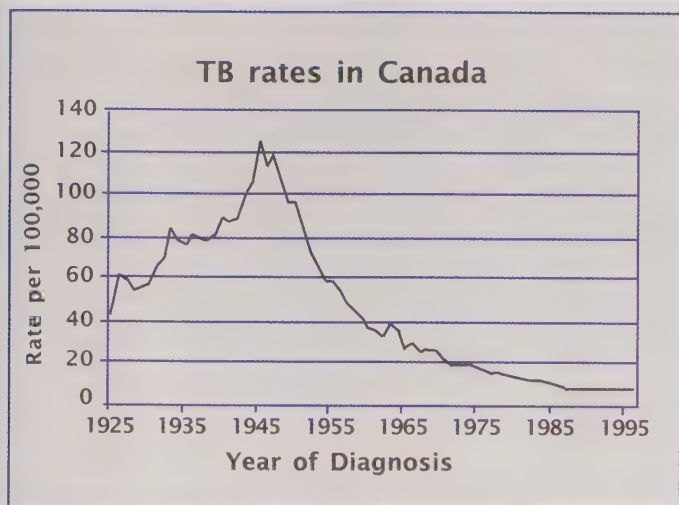
Each year, benefits are indexed by the appropriate indexing factor. For 2002:

- the general indexing factor (Modified Friedland or MF) is 0%, and
- the alternate indexing factor (Consumer Price Index or CPI) is 1.9%.

In the first two columns, you will find the section of the WSIA and the legislated dollar amount under that section. In the third, you will find the indexed amount for 2002. For more information about indexing, please refer to 18-01-02, Benefit Dollar Amounts, in the *Operational Policy* manual.

Section	Legislated dollar-amount	2002 \$ - amount
43(2)	The minimum annual amount for full loss of earnings (LOE) is the lesser of <ul style="list-style-type: none"> <li>• \$15,312.51, or</li> <li>• the worker's net average earnings (NAE) before the injury</li> </ul>	\$15,404.50
45(6)	Retirement pension: Benefit paid as a lump sum if it is less than \$1,145.63/year	\$1,152.51
46	Non-economic Loss (NEL) benefit: Base amount = \$51,535.57 Age factor: Plus/minus \$1,145.63 for each year worker is under/over age 45 Maximum amount multiplied by percentage of impairment = \$74,439.52 Minimum amount multiplied by percentage of impairment = \$28,631.22	\$51,844.99 \$1,152.51 \$74,886.75 \$28,803.23
	The benefit is paid as a lump sum if it is \$11,452.07 or less	\$11,520.87
48(2)	Lump sum to surviving spouse: Base amount = \$55,555.55 Age factor: Plus/minus \$1,388.88 for each year spouse is under/over age 40 Maximum lump sum = \$83,333.30 Minimum lump sum = \$27,777.76	\$61,032.03 \$1,525.79 \$91,548.01 \$30,516.00
48(4)	The minimum compensation amount payable for spouse and children = \$15,312.51/year	\$17,327.50
48(8)	If more than one person is entitled to receive periodic and lump sum payments as a spouse <ul style="list-style-type: none"> <li>• the total periodic payment does not exceed 85% of worker's NAE at the time of the injury, and</li> <li>• the total lump sum payment is limited to \$83,333.30</li> </ul>	\$91,548.01
48(13)	Aggregate lump sum payment for children when there is no surviving spouse = \$55,555.55	\$61,032.03
48(22)	Minimum burial or cremation expenses = \$2,083.32	\$2,288.70
54	Maximum earnings ceiling: 175% of the average industrial wage for Ontario for the year in which the accident takes place	\$64,600.00
<b>Pre-1998 WCA</b>		
39(1)	The minimum temporary total disability benefit to a worker is <ul style="list-style-type: none"> <li>• \$10,500/year when the NAE are equal to or more than \$10,500, or</li> <li>• the actual NAE if earnings are less than \$10,500/year</li> </ul>	\$15,404.50
50(3)	Maximum clothing allowance: <ul style="list-style-type: none"> <li>• upper limb prosthesis = \$184</li> <li>• lower limb prosthesis/back brace/leg brace = \$368</li> </ul>	\$255.55 \$511.12
147(14)	Additional monthly payment of up to \$200 for workers in receipt of permanent partial disability benefits (Benefit may be less as it is based on year of initial entitlement.)	\$209.54





## Changes to Schedule 3 TB entry

Legislative Cabinet revised Schedule 3 of the Act with the approval of the amending regulation (O. Reg. 444/01) on Nov. 31, 2001, following the recommendations of the Occupational Disease Panel (ODP Report No. 14A, Nov. 1997). The TB Schedule 3 entry now includes the following as process so that

- it would be consistent with the other occupational diseases listed in Schedule 3, and
- to reflect current language usage.

### Revised Schedule 3 entry for TB

COLUMN 1 Description of Disease	COLUMN 2 Process
Tuberculosis	Any employment in a health care facility, a laboratory as defined in the <i>Laboratory and Specimen Collection Centre Licensing Act</i> , or a reform institution, any employment in health care services or health care support services or any other employment for which there is a known risk of exposure to tuberculosis or to the tubercle bacillus

For questions about the changes to the TB policy or any of the changes to the changes to Schedule 3 contact the Medical and Occupational Disease Policy Branch at (416) 344-4365 or toll-free 1-800-387-5540 and ask for Ext. 4365 or email at [modpb@wsib.on.ca](mailto:modpb@wsib.on.ca).

## TB (tuberculosis) is now a leading cause of death in Canada

When drugs to treat TB were first discovered, TB in the developed world began to decline rapidly. Like smallpox, it was felt that TB would soon be eliminated. The rates of TB in Canada and the rest of the world initially declined, but since the 1980's the rate of TB has remained the same. It is now understood that there are three main reasons for the persistence of TB.

### 1 Drug-resistance

Antibiotics used to combat TB become ineffective if they are not used properly. When people fail to comply with continued long-term drug treatment, some of the bacteria that are more resistant to the drug can survive. These drug-resistant bacteria can breed, forming a new TB strain that proliferates despite drug treatment and can only be killed when new drugs are found. Multi-drug-resistance is beginning to be a problem in Canada.

### 2 Immigration from countries where TB is common

One third of the world's population is believed to have TB. TB has continued to be a major problem, particularly in the developing world where drug treatments are not readily available or affordable. To support immigration into Canada from these countries, the federal government must carefully watch for TB in the incoming population. Canadian immigration laws currently require that all immigrants older than ten years be screened for active tuberculosis, and that all positive cases be followed-up once entering Canada.

### 3 High risk population groups

In Canada, some population groups have a higher potential for infection by tuberculosis and thus have the potential for spreading TB:

- those whose immune system is compromised, such as patients with HIV;
- those located in economically depressed areas, such as poor and overcrowded inner-city areas, or isolated communities; and
- mobile, displaced populations such as the homeless.

## New policy

### Redirected Benefit Payments, 18-01-06

The Benefits Policy Branch has developed a new *Redirected Benefit Payments* policy, 18-01-06 in the new OPM which replaces *Assignments*, 05-01-06 in the Pre-Bill 99 OPM.

Policy 18-01-06 takes into account new agreements struck by the WSIB with agencies such as Canada Customs and Revenue Agency (formerly Revenue Canada).

The new policy also reflects current legal and administrative changes, which made the previous policy inaccurate and incomplete.

The Benefits Policy Branch worked with the WSIB's Operations and Legal Services divisions to update the policy, making it useful for lawyers, decision-makers, and those with a need to know how all types of assignment and garnishment requests should be handled.

The policy on Support Deduction Orders for family support or maintenance remains unchanged and continues to be governed by the *Automatic Deduction for Family Support* policy, 05-01-15 in the Pre-Bill 99 OPM.

The new policy applies to all redirection notices received by the WSIB on or after August 1, 2001. If you have questions about the new policy, please contact Steve Densmore, Policy Analyst, Benefits Policy Branch at (416) 344-4349 or toll-free 1-800-387-5540, Ext. 4349 or via email at [steve\\_densmore@wsib.on.ca](mailto:steve_densmore@wsib.on.ca).

## Revised policy

### Health Care Fees, 17-03-02

The WSIB has the authority under section 33 of the *Workplace Safety and Insurance Act* to set and review rates or fees paid to health care practitioners. The *Health Care Fees* policy, 17-03-02 has been revised to highlight legislative provisions prohibiting health care practitioners from charging fees beyond the set fee schedules established by the WSIB. Benefits Policy Branch worked with Health Services to revise the policy.

Since the approach to fee setting has not changed, the policy's original application date of January 1, 1993 continues to apply. For further information on specific fees please see our website [www.wsib.on.ca](http://www.wsib.on.ca) or contact Health Services at (416) 344-4526 or toll-free at 1-800-569-7919.

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# POLICY REPORT

Vol. 15 No. 2 December 2002


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 Workplace Safety &  
Insurance Board  
Commission de la sécurité  
professionnelle et de l'assurance  
contre les accidents du travail

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## Revised policy

# Traumatic Mental Stress

The WSIB recently reviewed its policy on mental stress. Over 130 stakeholders provided written submissions on a revision of the previous policy that considered entitlement for mental stress involving an acute (immediate or delayed) reaction to:

- a series of traumatic events – identified as the cumulative effect; and
- evidence of traumatic harassment.

The end result is a revised policy, *Traumatic Mental Stress*, 15-02-02 that will aid in the fair and consistent provision of benefits to workers affected by work-related traumatic mental stress; taking into account any cases where **cumulative** traumatic events have triggered a psychiatric/psychological response. As was the case with the previous policy, a worker will not be entitled to benefits for traumatic mental stress because of an employer's employment decision or actions (e.g., layoff due to plant closure).

## How has the policy changed?

### A single sudden and unexpected traumatic event

Previously, entitlement was accepted if a worker witnessed a single sudden and unexpected traumatic event of a horrific nature, **or** was actually harmed or threatened with violence in the workplace. Entitlement has now been expanded to also include being the object of harassment that involves physical violence or the threat of physical violence, **or** being placed in a life-threatening or potentially life-threatening situation. The event must arise out of and in the course of employment, and be:

- clearly and precisely identifiable
- objectively traumatic; and
- unexpected in the **normal** course of work.

Some examples might include:

- witnessing a fatality or a horrific accident
- being the object of an armed robbery
- being the object of a hostage-taking; or
- a worker's family, friends, or co-workers being the object of a death threat.

The worker must have suffered or witnessed, or heard the traumatic event first hand (e.g., speaking with the victim on the radio or telephone as the event is taking place).

### A series of events causing the cumulative effect

Sometimes the nature of an occupation will expose a worker to multiple, sudden and unexpected events. In these cases, a decision-maker must establish from clinical and other information that there were prior traumatic events, and that these events led to the worker's current psychological state, even if the worker was able to tolerate them in the past. A final reaction to a series of sudden and traumatic events is considered to be the cumulative effect. The last traumatic event that triggers the cumulative effect may not be the most traumatic in a series of events.

### An acute reaction – immediate or delayed

An acute reaction is a significant and severe reaction by the worker to a one-time or a series of work-related traumatic events that have a psychiatric/psychological response. An acute reaction is **immediate** if it takes place within four weeks of the event, **or delayed** if it occurs after four weeks. The evidence must be clear and convincing in the case of delayed onset that the psychiatric/psychological response is due to the sudden and unexpected traumatic event which arose out of and occurred in the course of employment.

## Extended Time Limits for Prosecuting Offences

Bill 57, the *Government Efficiency Act, 2001*, legislated changes to extend the time limits for prosecuting offences under the *Workplace Safety and Insurance Act* (WSIA). The following chart shows:

- the new time limits; and
- the date from when the relevant time limit applies.

Offence	New time limit	Date from when the time limit applies
s.149	No time limit	For all s.149 offences that the WSIB became aware of from June 29, 1999, forward, there is no time limit to lay charges.  (For all s.149 offences that the WSIB became aware of prior to June 29, 1999, the WSIB had two years from that date to lay charges.)
s.150-156	Two years	The WSIB must lay charges within two years of the date that it becomes aware of the most recent occurrence of the offence. This two-year time limit applies to all offences committed on or after December 29, 2000.  (For offences committed prior to December 29, 2000, the WSIB had six months from the date that the offence was alleged to have been most recently committed to lay charges).

Also, under Bill 57, an employer's failure to produce wage records became an offence under s.152 as of June 29, 2001. For this type of offence, as of June 29, 2001, the WSIB has two years from the date that it becomes aware of the most recently committed offence to lay charges. For more information about offences and penalties see policy 11-02-02, *Offences and Penalties – General*.

## WSIB to Continue Paying LOE Benefits on Bi-weekly Basis

The WSIB will not be converting bi-weekly Loss of Earnings (LOE) benefits to a monthly payment in claims that are 24-months post-accident.

When the WSIA became effective January 1, 1998, the WSIB had intended to pay LOE benefits on a monthly basis in these claims of more than 24-months. See document 18-03-02, *Payment of LOE Benefits* in the *Operational Policy* manual.

The WSIB has now made the decision to continue paying LOE benefits on a bi-weekly basis until workers reach age 65. Work has just recently been completed on the computer system that is used to pay LOE benefits to ensure bi-weekly benefits continue. As a result, 18-03-02 will be revised to reflect this decision.

If you have any questions respecting the policy change, please contact John Martin, Manager, Policy Development, Benefits Policy Branch at (416) 344-4339, or toll-free 1-800-387-0750 and ask for Ext. 4339.



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# Branch to Consider Appeals of Time Limit Decisions

As of October 2002, the WSIB Appeals Branch will now consider appeals relating to the extension of appeal time limit decisions. These appeals will be dealt with within 30 days of receiving submissions from the workplace parties, without the need for a completed objection form.

Previously, extending appeal time limits and permitting late filing was at the sole discretion of the operating area's decision-makers. The exercise of discretion was not itself subject to appeal through the WSIB's internal appeal systems.

## Appeals process

The workplace party should submit their appeal of the time limit ruling to the adjudicator. The matter will then be referred by the manager of the operating area handling the claim directly to a manager in the Appeals Branch for assignment to an Appeals Resolution Officer.

If an extension is granted, the claim will be returned and the usual Access/Objection Form process will be initiated.

The criteria generally used to consider time limit extensions includes the following:

- serious health problems (experienced by the workplace party or workplace party's immediate family) or the workplace party leaving the province/country due to the ill health or death of a family member;
- whether the worker had actual notice. This acknowledges that post-1998 decisions specifically refer to the time limits but pre-1998 decisions do not;
- the length of the delay;
- whether there are other issues in the appeal which were appealed within the time limits and which are closely related to the issues not appealed within the time limits;
- the significance of the issue in dispute; or
- whether the worker was able to understand the time limit requirements.

The following are issues which generally have a 30-day appeal time limit:

- decisions surrounding labour market re-entry plans
- job suitability decisions
- decisions on co-operation, s.40 of WSIA; and
- re-employment decisions, s.41 of WSIA.

All other decisions should have the six-month time limit applied. Decision-makers follow two guiding principles when determining which of the time limits should be used. For example:

- if a worker is maintaining a loss of earnings due to a medical inability to work, the time limit should always be six months, no matter what program is being closed. (Exception: when a specific job offer is involved); **and**
- where a letter contains decisions on multiple issues involving both time limits, the adjudicator should always use the six-month time limit.

Finally, where there is any doubt as to whether the real issue is about return to work or is impairment-related, the longer time limit applies.

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Section 120 of the WSIA provides that appeals to decisions relating to return to work or labour market re-entry must be filed within 30 days of the decision. Appeals to all other decisions must be filed within six months. The section also states that appeals may be filed "within such longer periods as the WSIB may permit."

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For further information please refer to *The Appeals System Practice & Procedures* on the WSIB's corporate website, or contact Paul Gilkinson, Manager, Appeals Branch at (416) 344-3551, or toll-free 1-800-387-0773.

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## Diagnostic requirements

Decision-makers will require an Axis I diagnosis in accordance with the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). Diagnosis may include:

- acute stress disorder
- post-traumatic stress disorder
- adjustment disorder; or
- an anxiety or depressive disorder.

For immediate acute reactions, a claim will be accepted if an appropriately regulated health care professional confirms the worker has a DSM-IV Axis I diagnosis. Where the acute reaction is delayed or the onset is due to cumulative effect or harassment, a claim will be adjudicated once there is a DSM-IV Axis I diagnosis provided by a psychiatrist or psychologist.

## Adjudicating traumatic mental stress claims

The WSIB has a team of claims management professionals dedicated to handling traumatic mental stress claims for all of Ontario. Part of this specialized team's goal is to help employers and workers determine ways to prevent or minimize the effects of traumatic mental stress, including early identification of risks and appropriate intervention methods.

## Application date

Policy 15-02-02 applies to any single traumatic event or, in the case of the cumulative effect, the most recent traumatic event taking place on or after January 1, 1989 (the date the WSIB formally began reviewing the issue of stress). For a copy of policy 15-02-02, please contact Knowledge Services at (416) 344-4355, or toll-free at 1-800-387-0750, Ext. 4355.

### *Season's Greetings*

May the warmth and joy of the season remain in your heart throughout the coming year. Wishing you a happy, healthy, and prosperous 2003.

*From the Policy and Research Division*

# POLICY REPORT



Workplace Safety &  
Insurance Board

Commission de la sécurité  
professionnelle et de l'assurance  
contre les accidents du travail

*Policy Report* subscriptions are free.

*Policy Report* is published by the Knowledge Services Branch of the Workplace Safety and Insurance Board. If there is any conflict between information in this publication and the *Workplace Safety and Insurance Act* (WSIA) or approved policy documents, the WSIA or the policy governs.

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Knowledge Services also publishes the *Operational Policy* manual and the *Employer Classification* manual. To purchase these publications, or to receive *Policy Report* please call (416) 344-4355, or 1-800-387-0750, Ext. 4355.

If you have any comments or questions about this issue, please contact the editor at:

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# POLICY REPORT

Vol.16 No.1 March 2003

**WSIB**  
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**CSPAAT**

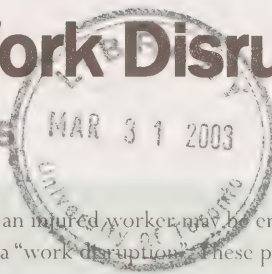
Workplace Safety &amp; Insurance Board

Commission de la sécurité  
professionnelle et de l'assurance  
contre les accidents du travail

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## Entitlement Following Work Disruptions

five new policies



Five new policies have been developed to assist decision-makers in determining whether an injured worker may be entitled to WSIB benefits and/or labour market re-entry (LMR) services when the worker has stopped working due to a "work disruption". These policies, now available in the *Operational Policy manual (OPM)*, cover all types of work disruptions, including:

- short-term or long-term—policy 18-01-08, *Entitlement Following Work Disruptions: Short-term and Long-term Layoffs*
- permanent—policy 18-01-09, *Entitlement Following Work Disruptions: Permanent Layoffs*
- seasonal—policy 18-01-10, *Entitlement Following Work Disruptions: Seasonal Layoffs*, and
- strikes or lockouts—policy 18-01-11, *Entitlement Following Work Disruptions: Strikes or Lockouts*.

Policy 18-01-07, *Entitlement Following Work Disruptions: General* is a general overview document that helps clarify elements and concepts that are common to all of the different types of work disruptions, such as: definitions, underlying entitlement principles, and general LMR considerations.

These new policies apply to all decisions made on or after March 3, 2003.

### Focus of new policies

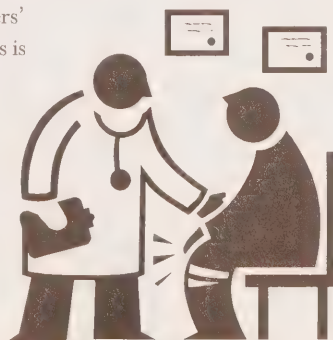
The new policies require decision-makers to focus on the concept of *employability* when determining whether further WSIB benefits and/or LMR services are in order following a work disruption. Essentially this means looking at whether an injured worker's work-related impairment and associated medical restrictions present a clear obstacle to the worker obtaining alternate work with the accident employer or another employer. When a worker's employability is clearly affected, the WSIB may provide:

- additional WSIB loss of earnings (LOE) benefits, temporary total disability benefits (TT), future economic loss (FEL) supplement, or s. 147(2) supplement, and possibly,
- LMR services.

The focus on employability is in keeping with the intent of the *Workplace Safety and Insurance Act (WSIA)* which is to facilitate workers' return to work with the accident employer and, when this is not possible, their re-entry into the labour market.

### Short-term layoffs

For short-term work disruptions, a worker's benefit status at the time of the work disruption is generally maintained. However, the WSIB may provide additional benefits/services to workers whose employability is clearly affected by their work-related impairment and associated medical restrictions.



Typical indicators that further benefits/services may be in order are that the worker:

- is in the early phase of recovery, and
- is receiving WSIB-approved active health care treatment, i.e., physiotherapy on a frequent basis, such as three times a week.

In practical terms, these workers could not reasonably be expected to conduct a job search, and the likelihood of another employer hiring them is low. For a full list of the indicators/factors to be considered, see the relevant policy listed above.

### Long-term or permanent layoffs

For long-term or permanent work disruptions, it is generally presumed that the worker will have to seek employment elsewhere.

Decision-makers, therefore, have to determine whether the worker:

- is labour market ready, or
- requires assistance to re-enter the labour market.

To make this determination, decision-makers have to consider whether the worker has a distinct disadvantage in finding suitable work as compared to an uninjured co-worker.

(Continued on page 6)

	<p align="center"><b>Short-term Layoffs</b> <b>Policy 18-01-08</b></p>	
<b>Recall Date</b>	<p>A short-term layoff has:</p> <ul style="list-style-type: none"> <li>• a specific recall date, or</li> <li>• no specific recall date, but the work disruption lasts or is expected to last, three months or less.</li> </ul> <p>If the recall date is beyond the three-month mark, the decision-maker has to determine the following:</p> <ol style="list-style-type: none"> <li>1 Was the recall date provided in writing?</li> <li>2 If a recall date <b>was provided</b>, how certain is it that a recall will occur on the date specified.</li> </ol> <p>If the above criteria suggest that the recall is likely to occur on the date specified, the work disruption continues to be as a short-term layoff past the three-month mark.</p>	
<b>Entitlement to Benefits</b>	<p align="center"><b>Entire Work-force Layoff</b></p> <p><b>General rule:</b> The worker's pre-layoff benefit status is maintained, i.e.:</p> <ul style="list-style-type: none"> <li>• if the worker is <b>not</b> receiving LOE/FEL or permanent disability (PD) benefits, additional benefits/services should probably not be allowed</li> <li>• if the worker is receiving <b>partial</b> LOE/FEL/PD benefits, the partial benefits should probably continue, or</li> <li>• if the worker is receiving <b>full</b> LOE/FEL/TT minus PD/TT benefits, the full benefits should probably continue.</li> </ul> <p><b>Likely exceptions to the general rule:</b> The following factors suggest that the worker's employability is clearly affected by the work-related impairment and associated medical restrictions and that additional WSIB benefits/services may be in order. The worker:</p> <ol style="list-style-type: none"> <li>1 is in the early phase of recovery</li> <li>2 is still receiving WSIB-approved active (non-maintenance) health care treatment (e.g., physiotherapy) on a frequent basis</li> <li>3 is on a graduated return to work (RTW) program</li> <li>4 requires a high degree of accommodation, or</li> <li>5 has an impairment that is a significant obstacle to finding alternate employment.</li> </ol> <p>The worker's benefits may be adjusted based on the worker's recovery.</p> <p>If the layoff is short (e.g., two weeks), and recurs every year (e.g., December or summer shutdown), the WSIB will not provide additional benefits to workers who only meet exceptions 4 and/or 5.</p>	<p align="center"><b>Partial Work-force Layoff</b></p> <p><b>General rule:</b> Entitlement to benefits is determined by considering the following in sequential order:</p> <ol style="list-style-type: none"> <li>1 Employer's re-employment obligations</li> <li>2 Workplace parties' co-operation obligations</li> <li>3 Primary cause of loss of earnings, i.e., do factors suggest that loss of earnings is primarily due to: <ul style="list-style-type: none"> <li>• the employment situation, or</li> <li>• the worker's work-related impairment.</li> </ul> </li> </ol> <p>*For the list of factors, please refer to the column on the left, "Likely exceptions to the general rule", items 1-5.</p> <p>The decision-maker must also consider whether the worker is unable to bump a co-worker with less severe impairment because of the work-related impairment.</p> <p>The worker's benefits may be adjusted based on the worker's recovery.</p>
<b>LMR Services</b> (for additional guidelines, see "LMR services" on page 6 of this newsletter).	<p>LMR services and the associated benefits <b>are generally not provided</b> if the worker is involved in a short-term layoff.</p>	



# 2003 Table of Rates

Every year, the WSIB reviews and sets the following rates after conducting an external survey of costs for each specific rate. The only exception is the minimum burial rate. This rate is indexed annually according to the alternate-indexing factor, the Consumer Price Index (CPI).

The rates apply as of January 1, 2003.

For more information on the rates please refer to the policy documents referenced in the table.

Benefit	Last year's rate	Rate in 2003	OP Document
<b>Independent Living Allowance</b>	<b>\$3,030.55/yr</b>	<b>\$3,127.53/yr</b>	17-06-02
<b>Personal Care Allowance</b>			17-06-05
General Attendant Rate*	\$6.85/hr	<b>\$6.85/hr</b>	
Personal Attendant Rate	\$10.20/hr	<b>\$10.53/hr</b>	
Skilled Attendant Rate	\$16.34/hr	<b>\$16.86/hr</b>	
Bookkeeping Fee	\$720.00 annually	<b>\$720.00 annually</b>	
*set at minimum wage			
<b>Clothing Allowance</b>	min. damage \$255.56 max. maj. damage \$511.12 max.	<b>min. damage \$255.56 max. maj. damage \$511.12 max.</b>	17-05-02
<b>Escorts</b>	\$54.80 /day	<b>\$54.80/day</b>	17-01-08
<b>Burial Expenses</b>	\$2,288.70 minimum \$11,197.10 maximum	<b>\$2,361.94 minimum \$11,657.64 maximum</b>	18-01-05 20-03-02
<b>Guide and Support Dog Allowance</b>	\$820.93 annually	<b>\$847.20 annually</b>	17-06-04
<b>Meal Allowance</b>			17-01-09
Breakfast	\$10.00	<b>\$10.00</b>	
Lunch	\$13.00	<b>\$13.00</b>	
Dinner	\$22.00	<b>\$22.00</b>	
<b>Hotels</b> (as accommodation)	Rates negotiated with various hotels	<b>Rates negotiated with various hotels</b>	17-01-09
<b>Room and Board</b> (as accommodation)	Up to \$600.00 per month	<b>Up to \$600.00 per month</b>	17-01-09
<b>Transportation</b>	\$0.34/km	<b>\$0.34/km</b>	17-01-09
<b>Witness Fees (hearings)</b>			09-02-04 in the Pre-Bill 99 OPM
Attendance	\$50.00	<b>\$50.00</b>	
Professional	Full day \$600.00 Half day \$300.00	<b>Full day \$600.00 Half day \$300.00</b>	
Non-professional	Full day up to \$110.96 Half day up to \$55.48	<b>Full day up to \$110.96 Half day up to \$55.48</b>	

# Facts and Figures 2003

Each year, benefits are indexed by the appropriate indexing factor. For 2003:

- the general indexing factor (Modified Friedland or MF) is 0.6%, and
- the alternate indexing factor (Consumer Price Index or CPI) is 3.2%.

In the first two columns, you will find the section of the WSIA and the legislated dollar amount under that section. In the third, you will find the indexed amount for 2003. For more information about indexing, please refer to 18-01-02, *Benefit Dollar Amounts*, in the *Operational Policy* manual (OPM).

Section	Legislated dollar-amount	2003 \$ - amount
43(2)	The minimum annual amount for full loss of earnings (LOE) is the lesser of <ul style="list-style-type: none"> <li>• \$15,312.51, or</li> <li>• the worker's net average earnings (NAE) before the injury</li> </ul>	\$15,496.93
45(6)	Retirement pension: Benefit paid as a lump sum if it is less than \$1,145.63/year	\$1,159.43
46	Non-economic Loss (NEL) benefit: Base amount = \$51,535.57 Age factor: Plus/minus \$1,145.63 for each year worker is under/over age 45 Maximum amount multiplied by percentage of impairment = \$74,439.52 Minimum amount multiplied by percentage of impairment = \$28,631.22	\$52,156.06 \$1,159.43 \$75,336.07 \$28,976.05
	The benefit is paid as a lump sum if it is \$11,452.07 or less	\$11,590.00
48(2)	Lump sum to surviving spouse: Base amount = \$55,555.55 Age factor: Plus/minus \$1,388.88 for each year spouse is under/over age 40 Maximum lump sum = \$83,333.30 Minimum lump sum = \$27,777.76	\$62,985.05 \$1,574.62 \$94,477.55 \$31,492.51
48(4)	The minimum compensation amount payable for spouse and children = \$15,312.51/year	\$17,881.98
48(8)	If more than one person is entitled to receive periodic and lump sum payments as a spouse <ul style="list-style-type: none"> <li>• the total periodic payment does not exceed 85% of worker's NAE at the time of the injury, and</li> <li>• the total lump sum payment is limited to \$83,333.30</li> </ul>	\$94,477.55
48(13)	Aggregate lump sum payment for children when there is no surviving spouse = \$55,555.55	\$62,985.05
48(22)	Minimum burial or cremation expenses = \$2,083.32	\$2,361.94
54	Maximum earnings ceiling: 175% of the average industrial wage for Ontario for the year in which the accident takes place	\$65,600.00
<b>Pre-1998 WCA</b>		
39(1)	The minimum temporary total disability benefit to a worker is <ul style="list-style-type: none"> <li>• \$10,500/year when the NAE are equal to or more than \$10,500, or</li> <li>• the actual NAE if earnings are less than \$10,500/year</li> </ul>	\$15,496.93
50(3)	Maximum clothing allowance: <ul style="list-style-type: none"> <li>• upper limb prosthesis = \$184</li> <li>• lower limb prosthesis/back brace/leg brace = \$368</li> </ul>	\$255.56 \$511.12
147(14)	Additional monthly payment of up to \$200 for workers in receipt of permanent partial disability benefits (Benefit may be less as it is based on year of initial entitlement.)	\$210.80



<p><b>Long-term Layoffs</b> <b>Policy 18-01-08</b></p> <p>It is considered long-term when it has lasted three months or more, if no recall date, or if a recall did not occur on the date provided, or if a recall date, but the date is far in the future and the likelihood of an actual recall occurring on that date is low. In point, it is generally presumed that the worker will have to seek employment elsewhere, and due to his/her work-related impairment and associated medical restrictions, may require assistance from the WSIB to re- enter the labour market</p> <p><b>General rule:</b> Workers who did qualify for additional benefits/services during the long-term layoff Additional benefits should probably continue to be paid beyond the three-month mark Medical monitoring of the claim file continues, with benefits adjusted when the worker is fit to do the pre-accident job or a suitable job and no longer requires active treatment and/or a graduated RTW program and the worker's medical restrictions are not an obstacle to finding a job If the suitable job is available in the general labour market, it would generally become the worker's SEB, with benefits adjusted accordingly If the decision-maker is unable to determine an appropriate SEB for the worker, and the worker meets the eligibility criteria for an LMR assessment, the WSIB offers an LMR assessment. Workers who did not qualify for additional benefits/services during short-term layoff and who are still unable to do their pre-accident job in the three-month waiting period is up: The decision-maker determines whether the worker's pre-layoff job is suitable and available in the general labour market If this is the case, then that suitable work would usually become the worker's SEB and, if appropriate, a partial benefit would be paid, based on the SEB. If the decision-maker is unable to determine an appropriate SEB for the worker, and the worker meets the eligibility criteria for an LMR assessment, then the WSIB offers an LMR assessment Please refer to "Assessing labour market readiness" and "SEB determination" page 6 for additional details.</p>	<p><b>Permanent Layoffs</b> <b>Policy 18-01-09</b></p> <p>There is little or no chance of a recall (i.e., there is a plant closure, or the employer has ceased business).</p> <p><b>General rule:</b> Guidelines for entitlement to benefits differ depending on whether:  <ul style="list-style-type: none"> <li>the worker requires close medical monitoring, or</li> <li>the worker's medical condition is stable.</li> </ul> <b>Workers requiring close medical monitoring:</b> The presence of any of the following factors indicates that the worker requires ongoing close medical monitoring:  <ol style="list-style-type: none"> <li>The worker is in the early phase of recovery.</li> <li>The worker is still receiving WSIB-approved active (non-maintenance) health care treatment (e.g., physiotherapy) on a frequent basis.</li> <li>The worker is on a graduated RTW program.</li> </ol> The above factors also suggest:  <ul style="list-style-type: none"> <li>that the worker's employability is clearly affected by the work-related impairment and associated medical restrictions, and</li> <li>that additional WSIB benefits/services may be in order and may be paid/ provided from the date the worker is permanently laid off.</li> </ul> For the next steps, please refer to the column on the left (Long-term Layoffs) starting with: "For workers who did qualify for additional benefits/services during the short-term layoff"</p> <p><b>Workers whose medical condition is stable:</b> For workers whose medical condition is stable but who are still unable to perform their pre-accident job because of their work-related impairment, please refer to the column on the left (Long-term Layoffs) starting with: "For workers who did not qualify for additional benefits/services during the short-term layoff"</p>	<p><b>Seasonal Layoffs</b> <b>Policy 18-01-10</b></p> <p>Seasonal layoffs usually have predetermined/predictable start and end dates. The loss of earnings during a seasonal layoff is generally due to the nature of seasonal employment, but may also be affected by a worker's inability to obtain other work due to the work-related impairment and associated medical restrictions.</p> <p><b>General rule:</b> The worker's pre-layoff benefit status is maintained, i.e.:  <ul style="list-style-type: none"> <li>if the worker is <b>not</b> receiving LOE, FEL, or PD benefits, additional benefits/services should probably not be allowed</li> <li>if the worker is receiving <b>partial</b> LOE/FEL/PD benefits, the partial benefits should probably continue, or</li> <li>if the worker is receiving <b>full</b> LOE/FEL/TT minus PD/TT benefits, the full benefits should probably continue.</li> </ul> <b>Likely exceptions to the general rule:</b> The following factors suggest that the worker's employability is clearly affected by the work-related impairment and associated medical restrictions and that additional WSIB benefits/services may be in order. The worker:  <ol style="list-style-type: none"> <li>is in the early phase of recovery</li> <li>is receiving WSIB-approved active (non-maintenance) health care treatment (e.g., physiotherapy) on a frequent basis</li> <li>is on a graduated RTW program</li> <li>requires a high degree of accommodation, or</li> <li>has an impairment that is a significant obstacle to finding alternate employment.</li> </ol> The worker's benefits may be adjusted based on the worker's recovery. <b>Note:</b> Factors 4 and 5 would likely not apply in cases where the injured worker has been able to find employment with another employer during the off-season.</p> <p>Generally, injured workers affected by a seasonal layoff will be assessed for LMR services when:  <ul style="list-style-type: none"> <li>the employment season has restarted, and</li> <li>it is determined that the employer is unwilling or unable to provide suitable work.</li> </ul> Please refer to policy 18-01-10 for additional details regarding entitlement to LMR services.</p>	<p><b>Strikes or Lockouts</b> <b>Policy 18-01-11</b></p> <p>Strikes and lockouts have unpredictable recall dates. The loss of earnings during a strike or lockout is generally due to an employment situation, but may also be affected by a worker's inability to obtain other work due to the work-related impairment and associated medical restrictions.</p> <p><b>General rule:</b> The worker's pre-layoff benefit status is maintained, i.e.:  <ul style="list-style-type: none"> <li>if the worker is <b>not</b> receiving LOE, FEL, or PD benefits, additional benefits/services should probably not be allowed</li> <li>if the worker is receiving <b>partial</b> LOE/FEL/PD benefits, the partial benefits should probably continue, or</li> <li>if the worker is receiving <b>full</b> LOE/FEL/TT minus PD/TT benefits, the full benefits should probably continue.</li> </ul> <b>Likely exceptions to the general rule:</b> The following factors suggest that the worker's employability is clearly affected by the work-related impairment and associated medical restrictions and that additional WSIB benefits/services may be in order. The worker:  <ol style="list-style-type: none"> <li>is in the early phase of recovery</li> <li>is receiving WSIB-approved active (non-maintenance) health care treatment (e.g., physiotherapy) on a frequent basis</li> <li>is on a graduated RTW program</li> <li>requires a high degree of accommodation, or</li> <li>has an impairment that is a significant obstacle to finding alternate employment.</li> </ol> The worker's benefits may be adjusted based on the worker's recovery.</p> <p>LMR services are generally not provided to a worker who is affected by a labour dispute unless exceptional criteria set out in this policy are met. Please refer to policy 18-01-11 for additional details regarding entitlement to LMR services.</p>
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## Examples of Work Disruptions

### Example 1 — Short-term layoff/partial workforce

**Scenario:** On February 11, 2003, David strains his lower back while working on the VROOM company's assembly line. David has re-employment rights under s. 41 of the Act.

On February 24, 2003, David returns to a modified job at VROOM, at no wage loss, with restrictions against heavy lifting, prolonged standing, and repetitive bending. To accommodate these restrictions, VROOM places David on the parts order desk. Following his doctor's instructions, David continues with physiotherapy treatments three times per week while doing the modified job.

On March 7, 2003, VROOM announces that 50 percent of their workforce is being laid off because of a general economic downturn. A recall date of April 21, 2003, is provided. David is one of the people laid off due to his relatively low seniority. David contacts his adjudicator with a request for further benefits/services.

**Q:** Is David entitled to further WSIB benefits/services?

**A:** Because this short-term work disruption involves only part of the workforce, the adjudicator first looks to whether the parties have complied with their re-employment and co-operation obligations under the Act. Finding no evidence of a breach of these obligations, the adjudicator then considers whether David's employability is clearly affected because of his work-related impairment and associated medical restrictions.

Using the factors in the chart on page 5 of policy 18-01-08, *Entitlement following Work Disruptions: Short-term and Long-term Layoffs*, the adjudicator notes that:

- David is still receiving regular, active health care treatment on a frequent basis
- his date of accident is fairly recent, and
- he is in the early phase of recovery.

Based on these factors, the adjudicator finds that the primary cause of David's loss of earnings following the lay-off is his work-related impairment. Therefore, the adjudicator restores David's full LOE benefits from the date of lay-off and continues to monitor David's recovery and adjusts benefits as needed.

### Example 2 — Seasonal layoff

**Scenario:** Elma drives a dump truck for the Salting For You company. She has been with the company for the last six years. Her work with this company is seasonal in that the company's operations are normally shutdown in April of every year and re-opened in November when the weather gets colder again. Elma typically plants trees in northern Ontario between April and November.

On February 25, 2003, Elma strains two fingers on her left (non-dominant) hand while adjusting the tailgate of her dump truck. Elma is off work entirely until March 3, 2003, when her doctor indicates that she can return to modified work as long as she does not have to use her left hand. Medical evidence on file shows that Elma will likely be able to resume full use of her left hand by April 5, 2003.

On March 3, 2003, through the co-operative efforts of Elma and her employer, Elma returns to a suitable job as an office clerk at her regular rate of pay. Elma's outpatient physiotherapy treatments end on March 14, 2003, at which point she is to begin a series of at-home strengthening and conditioning exercises.

On March 24, 2003, Elma returns to her pre-accident job at her regular rate of pay. On April 4, 2003, Salting for You closes its operations for the season and Elma contacts her adjudicator requesting further benefits/services.

**Q:** Is Elma entitled to further WSIB benefits/services?

**A:** The adjudicator notes that the general rule for seasonal work disruptions is that the benefit status at the time of the lay-off is normally maintained, i.e., if the worker was not in receipt of benefits at the time of the lay-off, further benefits are normally not in order. The adjudicator also notes that none of the exceptional factors (see "Likely exceptions to the general rule" on page 2 of policy 18-01-10, *Entitlement following Work Disruptions: Seasonal Layoffs*) pointing to further benefits are present.

Based on this information, the adjudicator concludes that the seasonal lay-off is the primary cause of Elma's loss of earnings after April 4, 2003, and not her work-related impairment. Therefore, Elma's claim for further benefits/services is denied.



#### Questions about entitlement following work disruptions? Call...

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## Entitlement Following Work Disruptions (continued from page 1)

### Assessing labour market readiness

When determining whether a worker requires assistance to re-enter the labour market, decision-makers examine the work the worker was doing at the time of the work disruption and consider the following questions:

- Is the worker unable to perform the pre-accident job due to the work-related impairment?
- Is it likely that the worker's impairment is permanent?
- How different is this work from the worker's pre-injury job (e.g., tasks, responsibilities, and rate of pay)?
- How long has the worker been doing this work?
- Is the work available in the general labour market and, if so,
  - are the wages comparable to what the worker was receiving, and
  - is the required productivity level the same as that being provided by the worker at the time of the work disruption?
- Does the pre-layoff work involve some form of accommodation?
- What is the likelihood that another employer will provide the required accommodation?

### SEB determination

Based on the answers to these questions, the decision-maker decides whether:

- the suitable work that the worker was doing at the time of the layoff (or is capable of doing), is an appropriate suitable employment or business (SEB), or
- a formal LMR assessment is needed to determine an appropriate SEB for the worker, and if necessary, an appropriate LMR plan.

### LMR services

Generally, the WSIB does not offer an LMR assessment to workers who have previously received LMR services unless they meet the eligibility criteria in policy 19-03-08, *LMR Re-assessments*. Workers may, however, be entitled to LMR services if they only received the early and safe return to work (ESRTW) component of vocational rehabilitation (VR) services in the past — see policies 19-01-01, 19-01-02, 19-01-03, and 07-03-09.

For those workers who meet the eligibility criteria for LMR services set out in the various work disruptions policies, the offer of an LMR assessment includes an explanation stating that:

- should the worker choose to accept the offer, the WSIB generally provides only one opportunity for the worker to receive an LMR assessment, and if required,
- an LMR plan

Workers who have recall rights under a collective agreement can defer participating in an LMR plan for up to twelve months from the date that it is determined that an LMR plan is necessary. This deferral is possible only if the LMR plan can be started before the final review of the worker's FEL/LOE benefits. If a worker chooses to defer the LMR plan, benefits are paid based on the worker's suitable employment or business (SEB). Once the worker begins the LMR plan, full benefits are restored.

Workers who are participating in LMR assessments/plans and are co-operating are generally entitled to full benefits.

LMR services and the associated FEL supplement can be provided only when specific eligibility criteria are met (see policy 18-04-11, *Supplement for Programs and LMR Plans Before and After 24 Months*).

### More information

For policy highlights, and case-specific examples, please refer to the chart on pages 2 to 4 of this newsletter. For complete details, refer to the actual policies as listed above.

# POLICY REPORT

**WSIB** Workplace Safety & Insurance Board  
**CSPAT** Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

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# POLICY REPORT

Vol. 16 No. 2 April 2003

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**ONTARIO**  
**CSPAAT** Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

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## WSIB improves Average Earnings Model

### Why the revised policies?

Using the operational experience acquired, the Average Earnings policies were revised to provide a clear and more complete direction. To help ensure consistency, the revised policies also include more practical examples.

Most of the new or revised Average Earnings policies apply to claims with **accident dates** on or after December 1, 2002 with the exception of the Recurrences and Calculating Net Average Earnings policies.

The revised Recurrences policy applies to all **decisions** made on or after December 1, 2002 (i.e., current decisions or reconsiderations for any claim with an accident date on or after January 1, 1998). The revised Calculating Net Average Earnings policy applies to claims with **accident dates** on or after January 1, 1998.

On December 1, 2002, the WSIB introduced an improved Average Earnings policy model.

The basic principles of the model did not change, however, the policies were reviewed to ensure that the guidelines are clear and equitable.

### Why the Model approach?

Based on the legislative requirements under s.53 of the WSIA, the WSIB adopted a model in January 1998 to help ensure that:

- the decision-making process is consistent and reliable
- each participant in the system is treated fairly, and
- similar cases are reviewed in a similar manner.

## General Policy Model

### Short-term Average Earnings

The short-term average earnings are the worker's earnings from the accident employer and all other employment at the time of the injury. Loss of earnings (LOE) benefits are based on the short-term average earnings and are paid for the first 12-weeks following the injury.

### Recalculating Average Earnings

If the worker was in permanent employment at the time of injury, a recalculation to long-term average earnings is not required unless it is not fair to continue paying LOE benefits based on the short-term average earnings. If a recalculation is required, the recalculation period is the 12-month period prior to the injury, subject to a break in the employment pattern.

If the worker was in non-permanent employment at the time of injury, a recalculation to long-term average earnings is automatically conducted. The recalculation period is the 24-month period prior to the injury, subject to a break in the employment pattern.

Following a recalculation, the worker's long-term average earnings are used to pay LOE benefits from the 13<sup>th</sup> week of the claim.

# Key improvements

## 18-02-02—Determining Short-term Average Earnings

### Overtime

Both mandatory and voluntary overtime are considered in the short-term rate (STR). For accidents occurring on or after December 1, 2002 that involve:

1. rotational shift workers—one complete shift is **now** used to calculate overtime if the rotation is shorter or longer than four weeks
2. time missed due to illness or vacation—the period is not extended beyond the four weeks or for rotational shift workers, the length of the shift rotation is not extended or shortened.

### Four weeks of earnings information not available

In some cases, a worker may not have four weeks of earnings prior to the accident. These cases may include:

- an injury sustained within the first four weeks on the job
- a shortening of the period (e.g., temporary shutdown, change in job grade, or job classification), or
- no prior employment history.

In these situations, for accidents occurring on or after December 1, 2002, the calculation of short-term average earnings is limited to the employment earnings with the accident employer divided by the period worked.

## 18-02-03—Determining Long-term Average Earnings—Workers in Permanent Employment

The WSIB recognizes that some workers that are permanently employed may have some fluctuation in their short-term earnings due to shift schedules. This fluctuation, however, is not due to the worker's continuously changing employment or to periods of unemployment.

For example, cashiers of a grocery store over the long-term generally average the same number of hours per week, even if the manner in which the hours worked or the number of days, over which the shifts are worked, may vary over the short-term.

Previously, this worker was considered a worker in “irregular employment” and was subject to an automatic recalculation at the 13<sup>th</sup> week of LOE. The recalculation would incorporate all employment earnings in the 24-month period prior to the accident, subject to any breaks in the employment pattern.

The document was improved to simplify the average earnings model by focussing on the nature of the employment at the time of injury rather than the nature of the earnings or method of payment.

The document now considers this same worker to be in **permanent** employment. As a result, there is no automatic recalculation at the 13<sup>th</sup> week of LOE. If the workplace parties or the WSIB determine that it would be unfair to continue paying LOE benefits based on the short-term rate, a recalculation may be conducted. The period of recalculation, however, is limited to the 12 month period prior to the date of accident, subject to any breaks in the employment pattern.



## 18-02-04—Determining Long-term Average Earnings—Workers in Non-Permanent Employment

Having eliminated the concept of “irregular employment”, this document now deals strictly with workers whose earnings fluctuate as they move from job to job.

### Break in employment pattern

The guidelines concerning a worker's break in employment pattern were also strengthened. In all cases, for workers in non-permanent employment, the recalculation period is shortened by a break in the employment pattern. If a shorter recalculation period is to be used, the start of the period is the date when the actual change occurred (i.e., the movement from one pattern of employment to another).

A **break in the employment pattern** is a change in the worker's employment significant enough to make the period before the break irrelevant to the determination of the worker's long-term earnings. This may include a change:

- from permanent employment to non-permanent employment, or vice-versa
- in status from dependent contractor to worker in non-permanent employment, or
- in status from worker with optional insurance to worker in non-permanent employment.

### Seasonal layoff patterns

For accidents occurring on or after December 1, 2002, if the worker's accident job is seasonal or cyclical and the duration of the lay-off period is established through past practice, the WSIB can determine the long-term average earnings of the worker by using the long-term average earnings of another worker similarly employed by the accident employer.

If this information is not available, the decision-maker can use the worker's short-term average earnings multiplied by the number of weeks in the season or cycle and add the probable Employment Insurance (EI) benefits payable. The calculation of the probable EI benefits is derived from the basic benefit rate and maximum amount payable set in the *Employment Insurance Act*. As a result, this amount is subject to change.

### Work pattern and the recalculation period

In some cases, the WSIB may need to extend or shorten a worker's recalculation period. For all accidents occurring on or after December 1, 2002, the WSIB must take into account the worker's seasonal or cyclical work pattern.

## 18-02-05—Determining Average Earnings—Concurrent Employment

Where a worker is concurrently employed at the time of injury, the average earnings are the earnings from all employment at the time of injury.

To be considered “concurrently employed” the following conditions must exist:

- the **accident employer** must have WSIB coverage (either compulsory, or by application including self-employment with optional insurance)
- the worker must have more than one contract of employment (contract for service or contract of service) at the time of injury
- there must be evidence of more than one continuing contract of employment during the four week period prior to the injury or some lesser period, and
- the worker must have received earnings from all concurrent employment in any of the four weeks prior to the injury.

### Illness or vacation

For all accidents occurring on or after December 1, 2002, if, in the four weeks before the injury, a worker did not receive earnings in the non-accident job(s) due to illness or vacation, the period is not extended. In these cases, the worker is not considered concurrently employed.

### Recalculation method

The policy also changed the rules for recalculating a worker's long-term average earnings. The new rules treat workers who are concurrently employed at the time of injury in the same manner as workers who are not concurrently employed.

For those workers who are either concurrently employed in:

- two or more permanent jobs, or
- a combination of permanent and non-permanent jobs,

the WSIB first calculates the long-term weekly average earnings from **each** job separately and then **adds** the two figures together to arrive at the concurrent long-term average earnings.

For those workers who are concurrently employed in two or more non-permanent jobs, the WSIB continues to calculate the worker's earnings from all employment in the recalculation period to arrive at the concurrent long-term average earnings.

## 18-02-06—Determining Average Earnings—Recurrences

In some cases, an injured worker may:

- receive LOE benefits based on either the STR or LTR,
- return to work at no loss of earnings, but later
- experience a recurrence of the original injury.

In these cases, the worker may be entitled to receive further LOE benefits, based on either the higher of the pre-injury or pre-layoff earnings.

### The document now provides clearer rules involving recurrences.

The “Recurrences” policy was rewritten to reflect the statutory requirements in s.53(6) of the WSIA. The policy applies to all **decisions** made on or after December 1, 2002. Therefore, the new policy also applies to a reconsideration of a previous decision for claims with an accident date on or after January 1, 1998.

### Policy improvement

The document now provides clearer rules involving recurrences. It helps ensure that in all cases involving recurrences, regardless of how long the worker returned to work, the worker's average earnings will **always** be based on the higher of the pre-injury or pre-layoff earnings as stated in s.53(6).

Since both the short-term average earnings and the long-term average earnings represent pre-injury earnings, the figure is compared with the pre-layoff earnings to determine what average earnings figure will be used at the time of a recurrence.

Although the higher earnings are always used, it is not fair to treat all recurrences similar to new claims by simply starting a new 12-week cycle of short-term average earnings. Accordingly, the revised policy provides complete direction on how the previous short-term average earnings cycle or long-term average earnings are affected by the recurrence.

## 18-02-07—Calculating Net Average Earnings

The WSIB determines the amount of a worker's net average earnings (NAE) by deducting from the worker's earnings the probable:

- income tax
- Canada Pension Plan (CPP) or Quebec Pension Plan (QPP) premiums, and
- employment insurance (EI) premiums payable by the worker.

The WSIB has improved the policy by referring to the legislated minimum and maximum compensation rate.

Most workers have their loss of earnings benefits based on 85 percent of their net average earnings. If a worker's net average earnings (annualized) are less than the legislated base figure of \$15,321.51 (indexed), the WSIA directs that the worker receives loss of earnings benefits based on his or her net average earnings. If the worker's net average earnings (annualized) are greater than \$15,321.51, the WSIA directs that the worker receives loss of earnings benefits based on 85 percent of his or her net average earnings.

If a worker's average earnings exceed 175 percent of the Ontario average industrial wage, the WSIA directs that the average earnings are deemed to be 175 percent of the average industrial wage. In other words, the average earnings are capped at the 175 percent level.

**For more on the statutory minimum and maximum amounts see the 2003 Facts and Figures in Policy Report Vol.16 No.1.**

## 18-02-08—Determining Average Earnings—Exceptional Cases

The guidelines for calculating short-term and long-term average earnings do not apply to workers that the WSIB classifies as:

- dependent contractors
- workers with optional insurance
- apprentices
- learners
- students
- pupils
- volunteer force members
- emergency workers, or
- Ontario Works participants.

In these cases, the WSIB does not use some of the rules normally followed to determine a worker's average earnings.

This new policy was introduced:

- to centralize these special rules for those workers who do not have their earnings calculated according to the general average earnings model but rather have their earnings based on other provisions set out in the WSIA and O. Reg. 175/98, and
- because the WSIB listened to and addressed the concerns respecting the calculation of average earnings for dependent contractors. These individuals are considered "workers" under the WSIA, however, the WSIB also recognizes the unique nature of some industries regarding employment relationships and method of payment. As a result, the WSIB does not use the general average earnings model for dependent contractors. Therefore, the average earnings are based on either:
- the net business income reported to Canada Customs and Revenue Agency (CCRA), or
- an audited financial statement.

The earnings 12 months prior to the date of accident are used to calculate the average earnings for dependent contractors.

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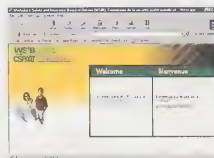
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# POLICY REPORT

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contre les accidents du travail

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## FEL & LOE policy revisions

# Bill 179 - Government Efficiency Act

The *Government Efficiency Act* (Bill 179) amended various provisions of the *Workplace Safety and Insurance Act* (WSIA) effective November 26, 2002. This change, which affects workers receiving either future economic loss (FEL) benefits and/or loss of earnings (LOE) benefits, provides for fairer wage loss benefits by extending the final review, or allowing additional reviews due to increasing impairment.

In particular, the final review provisions under s.44 of the WSIA were amended to allow for the payment of benefits where:

- the worker was involved in a labour market re-entry (LMR) plan and the plan was not completed at the time of the final review; or
- the worker experiences a significant deterioration resulting in a non-economic loss (NEL) re-determination and increase in the NEL benefit after the final review.

The WSIB's interim direction on the impact of the amended review provisions, pending a review of the affected policies, was outlined in the Clarification Document issued in March 2003 and posted on the WSIB's web site.

## Major changes

### 1) Deferral of final review when in an LMR Plan

The deferral of the final review when a worker is still involved in an LMR plan ensures the plan can be completed before the worker's wage loss entitlement is locked-in. The deferral is not time-limited but is determined by the length of the LMR plan as agreed to by all parties. Once the plan has been completed, the WSIB has thirty days to complete the final review. Although minor adjustments to the plan while in progress will not affect the deferral of the final review, the final review must take place once the plan has been fully completed, or if it is terminated for any reason.

#### Example

Joe had a work injury May 14, 1997 but was able to return to a suitable job with his employer three months later. He received a future economic loss (FEL) sustainability payment in March 1998 because he had a permanent impairment and it was not clear that his employer could

continue to provide the suitable job. In July 2002, Joe was laid off indefinitely. The WSIB conducted an LMR assessment, and as a result, developed an LMR plan that involved academic upgrading and a two-year training program. Joe's final FEL review was to take place in March 2003. Since he was still involved in the LMR plan at that time, the final review was delayed. If Joe completes the LMR plan as scheduled on June 17, 2005, the WSIB must carry out the final review by July 18, 2005.

### 2) Review due to significant deterioration

The ability of the WSIB to conduct a further review of the FEL or LOE benefits after the final review is based on the significant deterioration of the worker's condition. A "significant deterioration" is not defined in policy, but is considered any deterioration that will result in an increased permanent impairment. Based on the wording of Bill 179, the review can only take place once the increase has been confirmed. This means that a worker who is claiming a significant deterioration should first undergo treatment to improve his/her condition as much as possible. Once

# Bill 179 - Government Efficiency Act (cont'd from page 1)

no further improvement is likely, a NEL medical assessment should be arranged. It is not until that medical assessment has been completed; the results sent to the WSIB; and, the NEL benefit (permanent impairment) has been increased, that the WSIB can then review either the FEL or the LOE benefit.

In the case of workers getting FEL benefits, a FEL supplement may be paid during the period the worker is receiving further treatment. However, if workers are getting LOE benefits, the amount that was being paid at the final review must continue until the NEL re-determination. Then, an adjustment of the LOE can take place but only if the NEL benefit increases.

There are some further restrictions on this provision. Workers who were never assessed for a NEL benefit (permanent impairment) prior to the final review, would not be entitled to a review and possible payment of an LOE benefit after the final review. The reason for this is that only re-determinations leading to an increased NEL benefit allow an LOE review. An initial NEL determination is not a "re-determination". Also, workers who received a zero NEL assessment at any point, are not entitled to a review of their LOE benefit, because the WSIA does not allow a re-determination of a zero NEL assessment. This restriction also applies to worker's receiving a FEL benefit.

## Example

*Amanda's final review of her LOE benefit took place on January 9, 2004. Because she had continued to work with a wage loss, her LOE benefit was confirmed at \$58.00/week. She also received a 20% NEL payment. If Amanda stops working in July 2004 because her*

*work injury gets worse, she will have to undergo further treatment. After her treatment has finished, and if her condition has permanently deteriorated, the WSIB will have to arrange a NEL reassessment. If that assessment takes place in December 2004, and the WSIB confirms in January 2005 that her NEL payment should increase to 25%, the WSIB can then review her LOE benefit. She would have only received \$58.00/week until January 2005, but now the WSIB can adjust her LOE benefit from July 2004.*

## Policy revisions

The WSIB has now completed a full review of all policies that have been impacted by Bill 179. The necessary changes have been identified, and the revisions were approved in December 2003. A total of nine policies have been revised.

## Effective date

The effective date for Bill 179 is November 26, 2002. This has the following impact:

**Deferral of final review while in LMR** – A worker must be actively involved in an LMR plan continuing through November 26, 2002, or starting up after that date, in order for the final review to be delayed, if at the time of the final review, the LMR plan has not completed. LMR plans completed prior to November 26, 2002 are not affected.

## Reviewing FEL or LOE Benefits after NEL deterioration

– The WSIB decision to increase the NEL benefit because of a deterioration of the worker's permanent impairment must occur on or after November 26, 2002. This means the date the WSIB changes the impairment not the date the worker saw the physician who conducted the NEL medical assessment.

## Revision to the Burial Expenses policy

The WSIA (the Act) sets the minimum amount payable towards the expense of burial or cremation. The Act requires annual indexing of the minimum burial allowance by the alternate indexing factor, the Consumer Price Index. The minimum burial allowance for 2004 is \$2,399.74.

Historically, the WSIB set the maximum burial allowance at a level that covered the costs in the majority of claims (85<sup>th</sup> percentile of expenses claimed in prior year). In exceptional circumstances,

the burial expenses payable could exceed the maximum amount.

The WSIB recognizes the significant impact of a worker's death to the family and to the community. The policy has been revised to provide for the payment of all expenses reasonably connected to burial or cremation.

The revised policy applies to all deaths occurring on or after January 1, 2004 (see *Burial Expenses*, 20-03-02).



# More choice of Health Professional for injured or ill workers

As part of the WSIB's commitment to quality and timely health care, the WSIB has revised its policy on *Choice and Change of Health Professional*, 17-01-03, in the *Operational Policy* manual. The revised policy came into effect on January 1, 2004.

## How has the policy changed?

### Direct patient care access

Previously, workers could make their initial choice of health professional from a chiropractor or physician. If the worker sought care from any other health professional, the WSIB required the worker to obtain a referral from a chiropractor or physician. Direct patient care access has been extended to Physiotherapists and Registered Nurses (Extended Class). This means that injured workers may now choose to seek initial treatment from a Chiropractor, Physician, Physiotherapist, or a Registered Nurse (Extended Class).

### Who are Registered Nurses (Extended Class)?

Registered Nurses (Extended Class) are nurses with advanced education who passed the Extended Class examination. Under the 1998 *Expanded Nursing Services for Patients Act*, they have the independent authority to:

- Diagnose common disorders and diseases
- Prescribe and administer certain treatments and medications
- Order basis diagnostic tests such as ultrasounds, x-rays, and lab tests.

### Physiotherapists

The revised policy recognizes that Physiotherapists can provide assessments and treatments within their scope of practice under the *Regulated Health Professions Act* and *Physiotherapy Act*. This includes providing a "working diagnosis" for adjudication purposes. Physiotherapists (and chiropractors) are still expected to complete a treatment extension request if they believe that the worker requires treatment beyond the initial 12-week period.

### Treatment from more than one health professional

On occasion, a worker may need to, or choose to, obtain health care from more than one health professional for



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# POLICY REPORT

**WSIB** Workplace Safety & Insurance Board  
**CSPAT** Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

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professionnelle et de l'assurance  
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## FEL & LOE policy revisions

### Bill 179 - Government Efficiency Act

The *Government Efficiency Act* (Bill 179) amended various provisions of the *Workplace Safety and Insurance Act* (WSIA) effective November 26, 2002. This change, which affects workers receiving either future economic loss (FEL) benefits and/or loss of earnings (LOE) benefits, provides for fairer wage loss benefits by extending the final review, or allowing additional reviews due to increasing impairment.

In particular, the final review provisions under s.44 of the WSIA were amended to allow for the payment of benefits where:

- the worker was involved in a labour market re-entry (LMR) plan and the plan was not completed at the time of the final review; or
- the worker experiences a significant deterioration resulting in a non-economic loss (NEL) re-determination and increase in the NEL benefit after the final review.

The WSIB's interim direction on the impact of the amended review provisions, pending a review of the affected policies, was outlined in the Clarification Document issued in March 2003 and posted on the WSIB's web site.

## Major changes

### 1) Deferral of final review when in an LMR Plan

The deferral of the final review when a worker is still involved in an LMR plan ensures the plan can be completed before the worker's wage loss entitlement is locked-in. The deferral is not time-limited but is determined by the length of the LMR plan as agreed to by all parties. Once the plan has been completed, the WSIB has thirty days to complete the final review. Although minor adjustments to the plan while in progress will not affect the deferral of the final review, the final review must take place once the plan has been fully completed, or if it is terminated for any reason.

#### Example

Joe had a work injury May 14, 1997 but was able to return to a suitable job with his employer three months later. He received a future economic loss (FEL) sustainability payment in March 1998 because he had a permanent impairment and it was not clear that his employer could

continue to provide the suitable job. In July 2002, Joe was laid off indefinitely. The WSIB conducted an LMR assessment, and as a result, developed an LMR plan that involved academic upgrading and a two-year training program. Joe's final FEL review was to take place in March 2003. Since he was still involved in the LMR plan at that time, the final review was delayed. If Joe completes the LMR plan as scheduled on June 17, 2005, the WSIB must carry out the final review by July 18, 2005.

### 2) Review due to significant deterioration

The ability of the WSIB to conduct a further review of the FEL or LOE benefits after the final review is based on the significant deterioration of the worker's condition. A "significant deterioration" is not defined in policy, but is considered any deterioration that will result in an increased permanent impairment. Based on the wording of Bill 179, the review can only take place once the increase has been confirmed. This means that a worker who is claiming a significant deterioration should first undergo treatment to improve his/her condition as much as possible. Once

# Bill 179 - Government Efficiency Act (cont'd from page 1)

no further improvement is likely, a NEL medical assessment should be arranged. It is not until that medical assessment has been completed; the results sent to the WSIB; and, the NEL benefit (permanent impairment) has been increased, that the WSIB can then review either the FEL or the LOE benefit.

In the case of workers getting FEL benefits, a FEL supplement may be paid during the period the worker is receiving further treatment. However, if workers are getting LOE benefits, the amount that was being paid at the final review must continue until the NEL re-determination. Then, an adjustment of the LOE can take place but only if the NEL benefit increases.

There are some further restrictions on this provision. Workers who were never assessed for a NEL benefit (permanent impairment) prior to the final review, would not be entitled to a review and possible payment of an LOE benefit after the final review. The reason for this is that only re-determinations leading to an increased NEL benefit allow an LOE review. An initial NEL determination is not a "re-determination". Also, workers who received a zero NEL assessment at any point, are not entitled to a review of their LOE benefit, because the WSIA does not allow a re-determination of a zero NEL assessment. This restriction also applies to worker's receiving a FEL benefit.

## *Example*

*Amanda's final review of her LOE benefit took place on January 9, 2004. Because she had continued to work with a wage loss, her LOE benefit was confirmed at \$58.00/week. She also received a 20% NEL payment. If Amanda stops working in July 2004 because her*

*work injury gets worse, she will have to undergo further treatment. After her treatment has finished, and if her condition has permanently deteriorated, the WSIB will have to arrange a NEL reassessment. If that assessment takes place in December 2004, and the WSIB confirms in January 2005 that her NEL payment should increase to 25%, the WSIB can then review her LOE benefit. She would have only received \$58.00/week until January 2005, but now the WSIB can adjust her LOE benefit from July 2004.*

## **Policy revisions**

The WSIB has now completed a full review of all policies that have been impacted by Bill 179. The necessary changes have been identified, and the revisions were approved in December 2003. A total of nine policies have been revised.

## **Effective date**

The effective date for Bill 179 is November 26, 2002. This has the following impact:

**Deferral of final review while in LMR** – A worker must be actively involved in an LMR plan continuing through November 26, 2002, or starting up after that date, in order for the final review to be delayed, if at the time of the final review, the LMR plan has not completed. LMR plans completed prior to November 26, 2002 are not affected.

## **Reviewing FEL or LOE Benefits after NEL**

**deterioration** – The WSIB decision to increase the NEL benefit because of a deterioration of the worker's permanent impairment must occur on or after November 26, 2002. This means the date the WSIB changes the impairment not the date the worker saw the physician who conducted the NEL medical assessment.

## Revision to the Burial Expenses policy

The WSIA (the Act) sets the minimum amount payable towards the expense of burial or cremation. The Act requires annual indexing of the minimum burial allowance by the alternate indexing factor, the Consumer Price Index. The minimum burial allowance for 2004 is \$2,399.74.

Historically, the WSIB set the maximum burial allowance at a level that covered the costs in the majority of claims (85<sup>th</sup> percentile of expenses claimed in prior year). In exceptional circumstances,

the burial expenses payable could exceed the maximum amount.

The WSIB recognizes the significant impact of a worker's death to the family and to the community. The policy has been revised to provide for the payment of all expenses reasonably connected to burial or cremation.

The revised policy applies to all deaths occurring on or after January 1, 2004 (see *Burial Expenses*, 20-03-02).



# More choice of Health Professional for injured or ill workers



As part of the WSIB's commitment to quality and timely health care, the WSIB has revised its policy on *Choice and Change of Health Professional*, 17-01-03, in the *Operational Policy* manual. The revised policy came into effect on January 1, 2004.

## How has the policy changed?

### Direct patient care access

Previously, workers could make their initial choice of health professional from a chiropractor or physician. If the worker sought care from any other health professional, the WSIB required the worker to obtain a referral from a chiropractor or physician.

Direct patient care access has been extended to Physiotherapists and Registered Nurses (Extended Class). This means that injured workers may now choose to seek initial treatment from a Chiropractor, Physician, Physiotherapist, or a Registered Nurse (Extended Class).

### Who are Registered Nurses (Extended Class)?

Registered Nurses (Extended Class) are nurses with advanced education who passed the Extended Class examination. Under the 1998 *Expanded Nursing Services for Patients Act*, they have the independent authority to:

- Diagnose common disorders and diseases
- Prescribe and administer certain treatments and medications
- Order basic diagnostic tests such as ultrasounds, x-rays, and lab tests.

### Physiotherapists

The revised policy recognizes that Physiotherapists can provide assessments and treatments within their scope of practice under the *Regulated Health Professions Act and Physiotherapy Act*. This includes providing a "working diagnosis" for adjudication purposes.

Physiotherapists (and chiropractors) are still expected to complete a treatment extension request if they believe that the worker requires treatment beyond the initial 12-week period.

### Treatment from more than one health professional

On occasion, a worker may need to, or choose to, obtain health care from more than one health professional for

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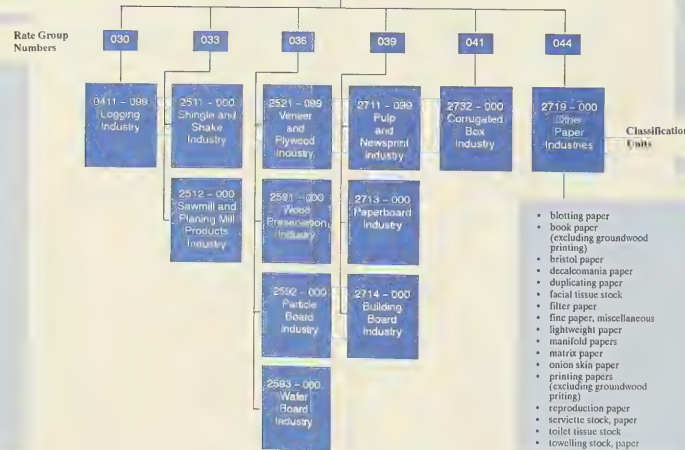
## Employer Classification – An Overview

### Industry Classes

There are 9 employer industry classes, each with an alphabetic identifier.

- A Forest Products
- B Mining and Related Industries
- C Other Primary Industries
- D Manufacturing
- E Transportation and Storage
- F Retail and Wholesale Trades
- G Construction
- H Government and Related Services
- I Other Services (e.g., Financial, Hospitality, Real Estate)

Industry Classes



### Rate groups

For the purposes of accurate classification and assessment, the employers in each class are further divided into rate groups. There are 219 rate groups, each identified by a 3-digit rate group number.

#### Example: Rate Groups for Class A – Forest Products

Rate group number	Description
030	Logging Industry
033	Sawmill, Planing & Shingle Mills
036	Veneer, Plywood & Wood Preservation Industry
039	Pulp/Newsprint/Board Industry
041	Corrugated Box Industry
044	Other Paper Industries

The WCB uses 3 basic criteria for establishing rate groups:

- One rate group should be clearly distinguishable from another.
- The employers in the rate group should have similar business activities which are comparable in historical cost experience.
- A rate group should be statistically credible.

For each rate group, the WCB has set a credibility threshold of at least 550 lost-time injury claims, over a 5-year period.

### Classification units (CUs)

The WCB has identified over 800 CUs. Employers are classified in one, or more, of the CUs that best describes their business activities. Each CU has its own title and 7-digit numeric identifier.

Since there are over 800 CUs and 219 rate groups, a rate group may have one CU in it, or several.

### CUs and SIC codes

The WCB's classification units for the most part parallel Statistics Canada's standard industrial classifications (SICs) in the 1980 edition of the SIC manual. Therefore, in almost all cases, the first 4 digits of the WCB's 7-digit CU codes are the same as the 4-digit SIC codes, and the last 3 digits in the CU code—referred to as the activity differentiator (AD)—are 000.

### Business activities

Business activities are the foundation of the WCB's new employer classification scheme. Similar business activities are listed together in the same classification unit. All employers engaged in these activities share the same 7-digit CU code, and title.

The WCB's definition of a business activity is any operation carried on by Schedule 1 employers which relates to producing a product or providing a service. This definition includes both profit-making and non-profit-making operations which are listed in, or may be added by application to, Schedule 1. Examples of non-profit-making operations in Schedule 1 include those carried on by privately or publicly funded social or government service agencies.

**SICs split** – In a number of cases, the WCB found the business activities listed under one SIC too diverse for WCB classification and assessment purposes. The SIC was, therefore, divided into 2 or more CUs, more precisely defining and differentiating the activities. In such cases, the first 4 digits of the CUs are identical, but the AD indicates the split. For example, the SIC entry titled Machine Shop Industry (SIC code 3081) was split into General Machine Shop Industry (CU 3081-001) and Automotive Machine Shop Industry (CU 3081-002).

**SICs merged** – In other cases, the WCB considered certain business activities which are listed in the SIC manual under different codes too similar to be classified and assessed separately. Therefore, the WCB amalgamated the business activities under one CU. Where this took place, the first 4 digits of the CU code are the same as one of the original SIC codes, but the 3-digit AD is 099. The Women's Clothing Industry, CU 2441-099, is an example of such an amalgamation of similar business activities. It is a combination of the SIC listings for the Women's Coat and Jacket Industry (SIC code 2441), the Women's Sportswear Industry (SIC 2442), the Women's Dress Industry (SIC 2443), and the Women's Blouse and Shirt Industry (SIC 2444).

**Splits & mergers** – Over time, as industry and the market-place change, CUs will continue to be reviewed and to undergo similar changes. They may even be split and, later, amalgamated with another CU. Such was the case with CUs 4241-002 and 4241-099. They share the same first 4 digits, but the last 3 digits reflect both a split and a merger, as follows.

Initially, the WCB split the SIC code 4241 in 2 parts, 4241-001 and 4241-002. However, after consulting further with employers, it was decided to incorporate the business activities of an entirely different SIC with the activities of CU 4241-001. This amalgamation created CU 4241-099; deleted 4241-001; and left CU 4241-002 the same.

**Out-of-province** – Special ADs have been assigned to 9 CUs. The first 4 digits of each of these CUs match SIC code 7711, but their ADs are 100, 200, 300, etc., up to 900—one for each of the 9 industry classes. If employers have an ancillary operation such as a clerical or administrative operation inside Ontario supporting out-of-province operations in their particular industry class, these clerical operations are classified in the appropriate CU.

**NOTE:** For 1993, all employers report their payroll information and accidents by rate group number. It is the rate group number—not the CU code—that appears on all WCB forms and correspondence relating to an employer's assessment. However, for internal purposes only, when the WCB registers employers, it classifies them at the CU level. Employers currently registered with the WCB have also been classified by CU.

### Application date

The policies referred to in this article are effective January 1, 1993.

For further information, please contact:  
Employer Registration and Assessment Branch  
Revenue Department  
Workers' Compensation Board  
(416) 927-3925  
1-800-387-8638



Workers'  
Compensation  
Board

Commission  
des accidents  
du travail

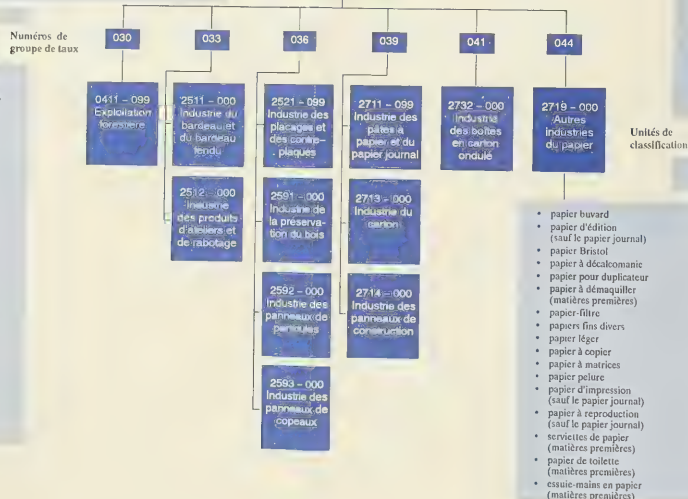
## Survol de la classification des employeurs

### Catégories

Il existe neuf catégories d'industries, désignées par une lettre de l'alphabet.

- A Produits forestiers
- B Industries des mines et industries connexes
- C Autres industries des matières premières
- D Industries manufacturières
- E Transport et entreposage
- F Commerce de détail et commerce de gros
- G Construction
- H Services gouvernementaux et services connexes
- I Autres services (p. ex., financiers, hôteliers, immobiliers)

Catégories d'industrie



### Groupes de taux

Pour assurer l'exactitude de la classification et de la cotisation, les employeurs de chaque catégorie sont répartis dans des groupes de taux. Il y a 219 groupes de taux, désignés par un numéro de trois chiffres.

Exemple : Groupes de taux de la catégorie A, Produits forestiers

Numéro de groupe de taux Description

- 030 Exploitation forestière
- 033 Scieries, ateliers de rabotage et usines de bardage
- 036 Industrie des placages, des contre-plaques et de la préservation du bois
- 039 Industrie des pâtes à papier, du papier journal et du carton
- 041 Industrie des boîtes en carton ondulé
- 044 Autres industries du papier

La CAT utilise trois critères de base pour établir les groupes de taux :

- Les groupes de taux doivent être nettement différents les uns des autres.
- Les employeurs du groupe de taux doivent avoir des activités commerciales semblables et des résultats en matière d'accidents comparables.
- Les groupes de taux doivent être crédibles du point de vue statistique.

Chaque groupe de taux comporte un seuil de crédibilité de 550 demandes d'indemnisation avec interruption de travail pour une période de cinq ans.

### Date d'application

Les politiques mentionnées dans le présent article sont en vigueur à compter du 1<sup>er</sup> janvier 1993.

### Unités de classification (UC)

La CAT a établi plus de 800 UC. Les employeurs sont classifiés dans une ou plus d'une UC, en fonction de leurs activités commerciales. Chaque UC a son titre et son identificateur numérique à sept chiffres.

Comme il existe plus de 800 UC et 219 groupes de taux, un groupe de taux peut avoir plus d'une UC.

### Les UC et les codes CTI

En règle générale, la structure de classification de la CAT correspond à la structure de la Classification type des industries (CTI), selon l'édition de 1980 préparée par Statistique Canada. Dans la plupart des cas, les quatre premiers chiffres du code de sept chiffres des UC de la CAT sont les mêmes que les quatre premiers chiffres des codes CTI, et les trois derniers chiffres du code des UC – le différentiateur d'activité – sont 000.

**Division du code CTI** – Dans certains cas, la CAT a constaté que les activités commerciales inscrites à un code CTI étaient trop variées pour la classification et la cotisation de la CAT. Le code CTI a alors été divisé en deux UC ou plus, de façon à mieux préciser et différencier les activités. En pareils cas, les quatre premiers chiffres sont identiques, mais le différentiateur indique la division effectuée. Par exemple, on trouve au code 3081, Ateliers d'usinage, la division suivante : 3081-001, Ateliers d'usinage général, et 3081-002, Ateliers d'usinage pour véhicules automobiles.

**Fusion du code CTI** – Dans d'autres cas, la CAT a jugé que certaines activités commerciales énumérées dans le manuel CTI à divers codes étaient trop semblables pour donner lieu à une classification et une cotisation distinctes. La CAT a donc regroupé ces activités commerciales sous une même UC. Les quatre premiers chiffres du code sont les mêmes que les quatre premiers chiffres des codes CTI, mais les trois derniers chiffres du code des UC – le différentiateur d'activité – sont 099. Le code 2441-099, Industrie des vêtements pour dames, est un exemple de fusion d'activités commerciales. Le code UC représente la fusion des désignations du code CTI pour l'industrie des manteaux et vestes pour dames (2441), l'industrie des vêtements de sport pour dames (2442), l'industrie des robes pour dames (2443), et l'industrie des blouses et chemises pour dames (2444).

### Activités commerciales

Les activités commerciales sont le fondement du nouveau mode de classification des employeurs de la CAT. Les activités commerciales semblables sont regroupées à l'intérieur de la même unité de classification. Tous les employeurs qui exercent de telles activités se voient attribuer le même code UC à sept chiffres, et la même désignation.

Pour la CAT, une activité est dite « commerciale », lorsqu'elle est exercée par un employeur de l'annexe 1 et qu'elle vise la fabrication d'un produit ou la prestation d'un service. Cette définition comprend les activités tant lucratives que non lucratives énumérées à l'annexe 1, ou pouvant lui être ajoutées. Les activités non lucratives des employeurs de l'annexe 1 peuvent comprendre, par exemple, celles exercées par les organismes sociaux ou gouvernementaux dont le financement est privé ou public.

**Division et fusion** – Au fur et à mesure que les industries et le marché du travail évoluent, les UC sont révisées et adaptées en conséquence. Les industries peuvent faire l'objet d'une division et, plus tard, d'une fusion avec une autre UC. C'est le cas, par exemple, des UC 4241-002 et 4241-099. Les quatre premiers chiffres sont les mêmes mais les trois derniers indiquent une division et une fusion.

Au départ, la CAT avait divisé le code CTI 4241 en deux, 4241-001 et 4241-002. Après consultation auprès des employeurs, il était décidé que les activités de l'UC 4241-001 fusionneraient avec celles d'un code CTI entièrement différent, ce qui a donné le code 4241-099; on a retiré l'UC 4241-001 et on a conservé l'UC 4241-002.

**Hors-province** – Neuf UC comportent un différentiateur particulier. Les quatre premiers chiffres correspondent au code CTI 7711 mais le différentiateur est 100, 200, 300, etc., selon les neuf catégories d'industrie. Si un employeur a en Ontario un secteur d'exploitation audinaire (tâches de bureau ou administratives) qui soutient des secteurs d'exploitation hors-province dans leur catégorie particulière, alors ces tâches administratives sont classifiées dans l'UC appropriée.

**REMARQUE :** En 1993, tous les employeurs doivent déclarer les renseignements sur leur masse salariale et les accidents en fonction des numéros de groupe de taux. Le numéro de groupe de taux est noté sur le code UC – paraître sur les formulaires et la correspondance de la CAT ainsi qu'il faut aux cotisations des employeurs. Toutefois, pour ses propres besoins, la CAT classe les nouveaux employeurs dans les UC lorsqu'elle en fait l'inscription. Les employeurs de la CAT inscrits ont également été classifiés dans les UC.

Pour plus de renseignements, veuillez communiquer avec la :

Direction de l'inscription des employeurs et des cotisations  
Service du revenu  
Commission des accidents du travail  
(416) 927-3925  
1-800-387-8638



# Completing the Physician's First Report - Form 8, and the Physician's Progress Report - Form 26

1. Give the date on which you first treated the worker—not the date when the worker was first treated by someone else.

2. Name the person and give the first treatment date, if known.

*Note: If the worker was first treated at a hospital emergency department, the adjudicator usually sends the worker a waiver to sign, authorizing the hospital to release to the WCB any additional medical information they may have gathered.*

3. Describe the activity performed and tools used by the worker at the time of the injury or onset of the disease, and any other specific details of the injury/disease.

4. Answer yes or no. If "yes," describe, e.g., if the worker had a previous back injury, describe it in detail. Include the date/year of the injury and whether it was work related.

*Note: This information helps decision-makers decide whether to reduce Schedule 1 employer costs by applying the Second Injury and Enhancement Fund (SIEF) policy. (See OP manual document 08-01-05.)*

5. State all relevant symptoms and related objective physical and/or neurological findings.

The information sent to the WCB must be specific, e.g.,

- low back pain with sciatica down the left lower limb into the great toe
- numbness of the left index, middle, and ring fingers.

*Note: Detailed information helps decision-makers determine initial entitlement.*

6. Give a diagnosis, e.g., lumbar sprain.

7. If no investigations are ordered, write "none." If investigations are ordered, list them by type, date performed or scheduled to be performed, and results, if known, e.g., x-rays of lumbar spine: (Dec. 21, 1993): Normal.

**Physician's First Report Form 8**

Workers' Compensation Board  
Commission des accidents du travail  
2 Bloor Street East  
Toronto, Ontario  
M4W 3C3

For WCB use only

Message to Physician:

Please complete in full and mail to the WCB within 48 hours of the patient's injury/disease if work related

Section 51 (R.S.O. 1990) of the Workers' Compensation Act authorizes you to release this information to the WCB

To ensure prompt processing of the claim, please return the patient's report to the WCB as soon as possible

Supplies of Physician's First Report, Form 8, are available on request from your local WCB office

Please complete in black ink or type and submit the original

Form No. [ ] Date No. [ ] Claim No. [ ]

Patient's Name: Doe, John  
First Name: John  
Last Name: Doe  
Address: 1123 Oakridge St.  
City/Town: Smith Falls  
Province: Ontario  
Postal Code: K7A 2A2  
Phone No.: (613) 555-5555  
Employer Name: Acme Co.  
Address: 1104 Maple Lane  
City/Town: Smith Falls  
Province: Ontario  
Postal Code: K7A 2A2  
Phone No.: (613) 555-5555

For WCB use only

1. Date you first treated patient's work: 04 January, '94

2. Name of injured worker: Doe, John

3. Patient's history of injury/disease: Patient states he lifted 80 lb. bag of cement and felt low back pain down the right side

4. History of previous injury/disease: 1991 - low back strain playing hockey. Off 1 week

5. Objective: Rem 60% Flexion 75%  
SIR 70% Extension 20%  
Subjective: Pain on prolonged standing/sitting  
Low back strain

6. X-rays: January 4, '94

7. Rest 5 days

8. Physio. after Flexion, Tension #3

9. Referral to specialist: Not at this time

10. Complete recovery expected: No

11. If yes, approximate time: Maximum of 4 weeks

12. Date when medical report on which previous claim was based was received: No

13. Date when medical report on which previous claim was based was received: No

14. Date when medical report on which previous claim was based was received: No

15. Date when medical report on which previous claim was based was received: No

16. Date when medical report on which previous claim was based was received: No

17. Date when medical report on which previous claim was based was received: No

18. Date when medical report on which previous claim was based was received: No

19. Date when medical report on which previous claim was based was received: No

20. Date when medical report on which previous claim was based was received: No

8. Describe
- modality (the kind of treatment, e.g., physiotherapy, chiropractic, medication, etc.)
  - frequency of treatment and medication
  - location of the treatment centre (if known), and
  - whether the worker is referred to a community clinic approved by the WCB. (Yes/No)
9. If "yes," give the name and address of the specialist seen or to be seen by the worker, and the assessment dates (if known).

*Note: VR caseworkers use answers to questions 10, 11, 12 and 13 to help them develop rehabilitation plans, e.g., travel restrictions may be important during a job search or may be crucial to the essential duties of a job that involves the operation of a motor vehicle.*

10. If "yes," approximate time.
11. If there are no medical restrictions, indicate.

If there are restrictions, describe them generally, e.g., no heavy lifting, no repetitive bending. Do not include specific functional capacities such as "no lifting greater than 25 lbs."

State if medical restrictions are temporary or permanent. If temporary, estimate time. This helps caseworkers decide if the injured worker's job placement should be temporary or permanent.

*Note: VR caseworkers use the information to develop goals for injured workers. (See OP manual document 07-02-04.)*

12. Check the yes/no box and, if necessary, describe.
13. Check yes/no box.

• Health Insurance No.—The number on the patient's Health card.

• Version Code—Assigned by the Ministry of Health for replacement of Health-card No.

• WCB Agency Billing No.—Enter the 10-digit billing no. assigned by WCB

• Your own Invoice No.—Maximum 8 characters alpha or numeric

• Service Date—Date on which the injured worker was assessed

• Fee Code—Code is pre-printed on WCB medical forms with a billing section

*Note: Physicians who do not complete the billing information will not be paid for medical reports.*

**Physician's Progress Report Form 26**

Workers' Compensation Board  
Commission des accidents du travail  
2 Bloor Street East  
Toronto, Ontario  
M4W 3C3

For WCB use only

Section 51 (R.S.O. 1990) of the Workers' Compensation Act authorizes you to release this information to the WCB

Please respond to all questions in black ink or type and return the original to the WCB

Patient's Name: Doe, John  
First Name: John  
Last Name: Doe  
Address: 1123 Oakridge St.  
City/Town: Smith Falls  
Province: Ontario  
Postal Code: K7A 2A2  
Phone No.: (613) 555-5555

For WCB use only

1. Date you first treated patient's work: 04 January, '94

2. Name of injured worker: Doe, John

3. Patient's history of injury/disease: Patient states he lifted 80 lb. bag of cement and felt low back pain down the right side

4. History of previous injury/disease: 1991 - low back strain playing hockey. Off 1 week

5. Objective: Rem 60% Flexion 75%  
SIR 70% Extension 20%  
Subjective: Pain on prolonged standing/sitting  
Low back strain

6. X-rays: January 4, '94

7. Rest 5 days

8. Physio. after Flexion, Tension #3

9. Referral to specialist: Not at this time

10. Complete recovery expected: No

11. If yes, approximate time: Maximum of 4 weeks

12. Date when medical report on which previous claim was based was received: No

13. Date when medical report on which previous claim was based was received: No

14. Date when medical report on which previous claim was based was received: No

15. Date when medical report on which previous claim was based was received: No

16. Date when medical report on which previous claim was based was received: No

17. Date when medical report on which previous claim was based was received: No

18. Date when medical report on which previous claim was based was received: No

19. Date when medical report on which previous claim was based was received: No

20. Date when medical report on which previous claim was based was received: No

1. Include all relevant symptoms and related physical findings, including neurological. Be specific as to location, e.g.,
- low back pain with sciatica down the left lower limb into the great toe
  - numbness of the left index, middle and ring fingers.

2. Give a specific diagnosis, e.g., lumbar sprain.

3. If no investigations are ordered, write "none." Do not leave space blank. If investigations are ordered, describe type and results. If previously reported it is not necessary to repeat here.

4. Describe the treatment plan for the diagnosis (item 2)

- modality (physiotherapy, chiropractic, medication etc.)
- frequency
- location (if known)
- community clinic referral made (yes/no).

State if the patient has been referred to a WCB-approved community clinic.

5. If the patient saw a specialist, give the name and address, and assessment dates, if possible. If no referrals were made, write N/A. Do not leave the space blank.

6. If yes, name the centre.

7. Indicate if recovery is affected by any significant work- or non-work-related factor.

8. Indicate, and state prognosis. When improvement is anticipated, indicate when a plateau in recovery will be reached.

9. Answer yes/no. If "yes," approximate date.

10 & 11. See item 11 in the Physician's First Report—Form 8.

12 & 13. Check yes/no. (See item 13 in Form 8.) Your name and address should be written clearly.

# Comment remplir le Premier rapport du médecin - Formulaire 8 et le Rapport d'évolution (médecin) - Formulaire 26

Indiquez les renseignements suivants :

1. Date à laquelle vous avez traité le travailleur la première fois, et non date à laquelle le travailleur a été traité pour la première fois par une autre personne

2. Nom de la personne et date du traitement, si connus

Remarque : Dans le cas des services des urgences d'un hôpital, l'agent envoyé habituellement au travailleur un formulaire d'autorisation qu'il doit signer. Ce formulaire autorise l'hôpital à divulguer à la CAT tout renseignement médical supplémentaire.

3. Activez effective et outils utilisés par le travailleur. Donnez tout autre détail précis se rapportant à la lésion ou à la maladie.

4. Oui ou non. Si «oui», précisez. Par exemple, si le travailleur a déjà subi une lésion au dos, décrivez cette lésion en détail. Indiquez la date où l'année de la lésion et précisez si la lésion était reliée au travail.

Remarque : Ce renseignement aide les décideurs à déterminer s'ils doivent réduire les coûts de l'employeur de l'annexe 1 en appliquant la politique sur le Fonds de garantie pour travailleurs réintégrés (FGTR). (Voir la politique 08-01-05)

5. Symptômes pertinents et constatations physiques ou neurologiques connexes.

L'information fournie doit être précise; p. ex. :

- douleurs lombaires accompagnées d'une sciatique irradiant dans la jambe gauche jusque dans le gros orteil
- engourdissement de l'index, du majeur et de l'annulaire gauches.

Remarque : Une information détaillée aide les décideurs à déterminer l'admissibilité initiale

6. Diagnostic; p. ex., entorse lombaire.

7. Aucun examen, inscrivez «aucun». Examen prescrits, indiquez le genre, la date à laquelle ils ont été effectués ou la date prévue, ainsi que les résultats, si connus (p. ex., radiographies de la colonne lombaire, 21 déc. 1993, normales).

- Modalité (physiothérapie, chiropratique, médicaments, etc.)
- Fréquence des traitements et médicaments
- Emplacement de l'établissement de soins, si connu,
- Orientation vers une clinique communautaire approuvée par la CAT (oui ou non).

Workers' Compensation Board		Commission des accidents du travail		1 <sup>er</sup> rapport du médecin	
Formulaire 8		Formulaire 8		Formulaire 8	
Message au médecin		Veuillez remplir le formulaire en entier et le retourner par la poste d'ici 48 heures à la CAT ou au médecin du patient en relation avec le travail.			
L'annexe 1 (R.O. 1990) de la Loi sur les accidents du travail vous autorise à divulguer les renseignements suivants à la CAT.		Veuillez répondre à toutes les questions, à l'encore noire ou à la machine et retourner l'original à la CAT.			
Veuillez remplir à l'encre noire ou à la machine et retourner l'original.		Veuillez remplir à l'encre noire ou à la machine et retourner l'original.			
Nom du patient		Nom du patient		Nom du patient	
Prénom		Prénom		Prénom	
Nom de famille		Nom de famille		Nom de famille	
Date de naissance		Date de naissance		Date de naissance	
Sexe		Sexe		Sexe	
Adresse		Adresse		Adresse	
Ville		Ville		Ville	
Province		Province		Province	
Code postal		Code postal		Code postal	
Téléphone		Téléphone		Téléphone	
Date de l'examen		Date de l'examen		Date de l'examen	
Date du prochain rendez-vous		Date du prochain rendez-vous		Date du prochain rendez-vous	
Durée de l'examen		Durée de l'examen		Durée de l'examen	
Type de lésion		Type de lésion		Type de lésion	
Description de la lésion		Description de la lésion		Description de la lésion	
Symptômes et constatations physiques		Symptômes et constatations physiques		Symptômes et constatations physiques	
Diagnostic		Diagnostic		Diagnostic	
Examen prescrits		Examen prescrits		Examen prescrits	
Médicaments		Médicaments		Médicaments	
Physiothérapie		Physiothérapie		Physiothérapie	
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# Case study: Rating a NEL impairment and calculating the benefit (Policy Report Vol. 5 No. 6)

Following her work-related injury, Jenny Belanger received treatment from her physio and no dual therapy arranged by the WCB at a community clinic. During her medical rehabilitation, Jenny's decision-maker kept track of the continuous improvements she was making (physicians' reports, and clinic reports).

Jenny returned to work and her decision-maker continued to monitor her medical reports. When they indicated that no further job improvement was likely, the decision-maker sent Jenny with a copy to the accident employer's letter advising her that she had reached (MMR) maximum medical rehabilitation (see 05-02-11) and that she was eligible for a NEL rating. Since it appeared she had a permanent impairment

To be eligible for the NEL benefit,\* stated the letter, "you will have to be examined by a physician who is trained in treating and evaluating your type of injury. We will send you a list of doctors for you to choose from, as well as a letter that explains the whole process." At this point the decision-maker contacted the area of the WCB that looks after the NEL process and advised them to contact Jenny.

From the list of physicians sent to her, Jenny chose the one she wanted to conduct her NEL assessment and told the NEL clerk immediately. The clerk set up an appointment with the physician, gave all the details to Jenny, and sent the physician a set of the medical documents from Jenny's claim file along with the NEL forms needed to record the results of her assessment.

The NEL form, designed to capture as much information as possible in the simplest way are listed on the Non-Economic Loss Summary Report, the first form illustrated below. These required for Jenny's assessment are checked off.

The Non-Economic Loss Summary Report allows the doctor to give a brief overview of Jenny's condition and medications, indicate if there is a conflict of interest, and sign off.

On the Likely Future Consequences form, the physician indicated that the condition of Jenny's knee should remain stable, but that there may be changes in the condition of the knee in the future.

On the Soft Tissue Pain Diagram, note that Jenny, herself, indicated the area of pain and when it occurs.

On the Injury Factors, Recording Form, the physician indicated that Jenny had a range of motion of 130 degrees. If it was in the knee, it is 150 degrees. It was noted that she could not fully do 10 degrees, straightened her knee. When the leg is straight, it is at an angle to the knee. Jenny also indicated a turn between the surfaces of the articular bones.

The physician marked "N/A" on the Lower Extremity, Neurology Reporting form (not illustrated), completed the Non-Economic Loss Billing form (not illustrated) and a locked copy, then made sure nothing was missed.

The WCB's physio and who conduct a NEL assessment be thorough about the completion of the forms, since the rate used to determine the degree of a worker's impairment is

Workers' Compensation Board

Commission des indemnités

Medical Assessment Set - Lower Extremity Set - Summary Report

99999999-9

1. Changes expected within the next two years

2. Changes expected beyond two years from now

As this is a weight-bearing joint, there is potential for increased pain and decreased ROM (range of motion)

Degenerative changes in knee structure

Potential development of arthritis

Workers' Compensation Board

Commission des indemnités

Medical Assessment Set - Lower Extremity Set - Summary Report

99999999-9

1. Changes expected within the next two years

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As this is a weight-bearing joint, there is potential for increased pain and decreased ROM (range of motion)

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Medical Assessment Set - Lower Extremity Set - Summary Report

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1. Changes expected within the next two years

2. Changes expected beyond two years from now

As this is a weight-bearing joint, there is potential for increased pain and decreased ROM (range of motion)

Degenerative changes in knee structure

Potential development of arthritis

The physician mailed the package of forms to the WCB immediately. (Physicians have 14 days from the examination to return them.)

Upon receipt of the report, Jenny's NEL adjudicator checked all the information and, since everything was O.K., the NEL clerk copied all the forms and sent them to Jenny and the accident employer.

The WCB, workers and employers have 45 days from the date the forms are mailed, not to object to the findings. Jenny had no objection to the assessment as the forms clearly described the extent of her impairment. But she did have a

good question, and called the WCB to get an answer. "What happens," she asked, "if my knee gets worse over time?"

The NEL adjudicator responded by telling her about s-42(21) of the Act.

"A worker may apply for a redetermination... if the worker has suffered a significant deterioration of condition that was not anticipated."

"If your knee gets significantly worse," the adjudicator continued, "we can have a re-evaluation 12 months after your most recent NEL decision."

Jenny understood, and asked when she would get her cheque.

"Even though you agree with the NEL assessment," her decision-maker responded, "and we have to wait for your employer's opinion. And even if your employer agrees tomorrow, the Act says we can't start the calculation until the 46th day after mailing the reports to you and your employer. So it'll be a couple of months before it's all finished."

Establishing degree of permanent impairment

To arrive at the percentage of permanent impairment, Jenny's NEL adjudicator took the following steps, referring carefully to the tables and chart from the AMA Guides, reproduced below for this case study.

- Using Table 39 (below left)
- convert the degrees of flexion to percentage of impairment of lower extremity
- Flexion of 130 degrees = 7%

- convert degrees of extension to percentage of impairment of lower extremity
- Extension lag of 10 degrees = 1%
- Add values for flexion and extension (as directed by the AMA Guides)
- Flexion + extension = 8% A
- Using Table 40 (2nd from left below) look up the value of lower extremity
- Note: The range of values is 0-10%

The NEL adjudicator checked 10%, noting the physician's comments on the Lower Extremity Recording form

one term meniscus 10% B

- Using the Combined Values Chart (2nd from left below)
- locate the larger value, i.e. B - 10%, on the side of the chart,
- locate the smaller value, i.e. A - 8%, at the bottom of the chart

find the combined value at the intersection of A and B (17%)

combined value 17%

- Using Table 46 (below) find the relationship of lower extremity impairment (17%) to impairment of the whole person
- whole person impairment = 7%

Calculating Jenny's NEL benefit

The Act directs that to calculate a NEL benefit the WCB must multiply the base amount of \$45,000

plus \$1,000\* for each year the worker is over age 45 at the time of the accident or minus \$1,000\* for each year the worker is over age 45 at the time of the accident

by the percentage of permanent impairment. The maximum amount that can be added or subtracted is \$20,000.\*

Table 39. Impairment Due to Amputation, Abnormal Motion and Ankylosis of the Knee Joint

Amputation	% Impairment of Lower Extremity
At Joint	90
Abnormal Motion*	
Average range of Flexion-Extension is 150°	
Value to total range of joint motion is 100%	
Retained active flexion of:	% Impairment of Lower Extremity
0°	53
10°	49
20°	46
30°	42
40°	39
50°	35
60°	32
70°	28
80°	25
90°	21
100°	14
110°	11
120°	7
140°	4
150°	0
Extension back to (extension lag):	% Impairment of Lower Extremity
0° (neutral position)	0
10°	1
20°	1
30°	1
40°	1
50° to 150° (full flexion)	90

\*If a permanent joint ankylosis is required for maximum stability, there is a 50% impairment of the lower extremity, although there may be full range of motion of the knee joint. This rating does not apply to any other types of full knee ankylosis.

Table 40. Impairment Ratings of the Lower Extremity For Other Disorders of the Knee

Disorder	Impairment of Lower extremity*
1. Patellofemoral (with loss of strength)	5-15%, combined with impairment for loss of motion*
2. Torn meniscus, meniscocyst, or partial meniscocyst	0-10%, for one meniscus; 0-25%, for both menisci; combine with impairment for loss of motion*
3. Knee replacement arthroplasty	20%, if prosthesis or operated; extremity is in optimum position
4. Patella replacement only	Same as for patellofemoral
5. Arthritis due to any cause including trauma; chondromalacia	0-20% according to deformity
6. Anterior cruciate ligament loss	0-15%, combined with impairment for loss of motion*
7. Posterior cruciate ligament loss	0-15%, combined with impairment for loss of motion*
8. Collateral ligament loss	10% for moderate instability; 20% for marked instability
9. Posttraumatic valgus deformity (if over 15°)	10%, combined with impairment for loss of motion*
10. Posttraumatic valgus deformity (if over 20°)	10%, combined with impairment for loss of motion*

\*See Table 39 for impairment ratings for loss of motion

The combining of any impairment value in this table with any other impairment in the table with impairment for loss of motion is to be done using the Combined Values Chart

Combined Values Chart

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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Table 46. Relationship of Impairment of the Lower Extremity to Impairment of the Whole Person

% Impairment of Lower Extremity	% Impairment of Whole Person
0 = 0	34 = 14
1 = 0	35 = 14
2 = 1	36 = 14
3 = 1	37 = 15
4 = 2	38 = 15
5 = 2	39 = 16
6 = 2	40 = 16
7 = 3	41 = 16
8 = 3	42 = 17
9 = 4	43 = 17
10 = 4	44 = 18
11 = 4	45 = 18
12 = 5	46 = 18
13 = 5	47 = 19
14 = 6	48 = 19
15 = 6	49 = 20
16 = 6	50 = 20
17 = 7	51 = 20
18 = 7	52 = 21
19 = 8	53 = 21
20 = 8	54 = 22
21 = 8	55 = 22
22 = 9	56 = 22
23 = 9	57 = 23
24 = 10	58 = 23
25 = 10	59 = 24
26 = 10	60 = 24
27 = 11	61 = 24
28 = 11	62 = 25
29 = 12	63 = 25
30 = 12	64 = 26
31 = 12	65 = 26
32 = 13	66 = 27
33 = 13	67 = 27

Jenny Belanger was 27 years old (18 years under the age of 45) at the time of her injury. Her permanent impairment (whole person) was assessed at 7%.

The formula in s. 42(2) is

$$NEL = \left( \frac{Base}{Age} \right) \times \left( \frac{Age}{Age} \right) \times \text{permanent impairment}$$

Jenny's NEL adjudicator

uses the base amount of \$45,000, indexed in 1994 to \$50,973.19

adds the NEL adjustment factor of \$1,000, indexed in 1994 to \$1,132.62 for 18 years.

multiples by the percentage of the whole person impairment of 7%.

$$NEL \text{ benefit} = \$50,973.19 + (18 \times \$1,132.62) \times 7\%$$

$$NEL \text{ benefit} = \$4,995.22$$

The NEL adjudicator confirmed in a letter to Jenny that her degree of permanent impairment is 7%, the amount of her NEL benefit is \$4,995.22, and that since it is less than \$10,000\*, the WCB pays it as a lump sum. Jenny got her payment with interest at the date of MMR about a week after the calculation was done.

Note: If Jenny's NEL benefit was more than \$10,000\*, the WCB would pay the benefit on a monthly basis for life. She would, however, have the right to ask for the total NEL benefit as a lump sum payment.

\*These are 1990 dollars. All amounts stated in the Act are indexed annually for inflation on indexing benefits, see OP manual document 05-02-12.

# Etude de cas : Détermination du degré de déficience et calcul de l'indemnité pour PNE (Bulletin des politiques, vol. 7, n° 6)

À la suite de sa lésion professionnelle, Jenny, 45 ans, a vu ses mouvements de son bras droit, et la CAT a pu les évaluer. Les données nécessaires pour qu'elle soit une thérapie médicale dans une clinique communautaire. Pendant la période de rééducation médicale de Jenny, le docteur chargé du dossier de Jenny a suivi les progrès que Jenny a réalisés en tant que membre des rapports professionnels médicaux et de la clinique.

Jenny a regardé le travail, et le docteur a continué d'étudier les rapports médicaux, et les données. Lorsque ces rapports ont révélé que l'état

de la travailleuse ne s'améliorerait vraisemblablement pas pendant un an, Jenny a demandé à la CAT d'être évaluée par un médecin spécialiste en rééducation médicale (RM) pour évaluer son état de déficience permanente.

Le lettré peut se voir, et il a dit : « Pour que la CAT détermine si vous avez droit à une indemnité pour perte non économique (PNE), vous devez être évalué par un médecin expérimenté dans le

diagnostic et l'évaluation du genre de lésion que vous avez. Vous vous êtes vu par un médecin expérimenté dans le diagnostic et l'évaluation du genre de lésion que vous avez. Vous vous êtes vu par un médecin expérimenté dans le diagnostic et l'évaluation du genre de lésion que vous avez. Vous vous êtes vu par un médecin expérimenté dans le diagnostic et l'évaluation du genre de lésion que vous avez.

vous avec le médecin choisi, dans le Jany de la prévision à ce sujet et envoyé au médecin un copie des documents médicaux figurant un dossier d'indemnité de la travailleuse ainsi que les formulaires remplis à la PNE déverser pour évaluer les résultats de l'évaluation.

Jenny lui fit savoir, et le docteur a précisé que l'état du genre de Jenny devrait demeurer stable, mais que les changements pourraient survenir. Jenny elle-même a indiqué sur le formulaire «Démontre - Demontre aux autres dans la région

ou elle revenait de la douleur ainsi que les mouvements qui lui occasionnaient de la douleur. Sur le «Formulaire d'évaluation des données - Membres inférieurs», le médecin a noté que la flexion de Jenny était de 130° (la flexion normale du genre est de 150°). Il a également noté que la travailleuse ne pouvait pas accomplir les tâches de la vie quotidienne.

Le médecin a noté «50» sur le «Formulaire d'évaluation des données - Membres inférieurs», membres inférieurs (non droit) et a noté le «Formulaire d'évaluation des données - Membres inférieurs». Il a ensuite vérifié tous les formulaires pour s'assurer qu'il n'avait rien oublié.

Le médecin a noté «50» sur le «Formulaire d'évaluation des données - Membres inférieurs», membres inférieurs (non droit) et a noté le «Formulaire d'évaluation des données - Membres inférieurs». Il a ensuite vérifié tous les formulaires pour s'assurer qu'il n'avait rien oublié.

Formulaire de demande d'indemnité pour PNE

1. Changements prévus dans les deux prochains années

2. Changements prévus au-delà des deux prochains années

3. Changements prévus au-delà des deux prochains années

Formulaire de demande d'indemnité pour PNE

1. Changements prévus dans les deux prochains années

2. Changements prévus au-delà des deux prochains années

3. Changements prévus au-delà des deux prochains années

Formulaire de demande d'indemnité pour PNE

1. Changements prévus dans les deux prochains années

2. Changements prévus au-delà des deux prochains années

3. Changements prévus au-delà des deux prochains années

Formulaire de demande d'indemnité pour PNE

1. Changements prévus dans les deux prochains années

2. Changements prévus au-delà des deux prochains années

3. Changements prévus au-delà des deux prochains années

Tableau 39. Déficience conduisant à une amputation, une mobilité anormale ou une ankylose au niveau de l'articulation du genou

Tableau 40. Barème de taux réduits à la déficience du membre inférieur résultant d'autres troubles du genou

Tableau 41. Barème de taux réduits à la déficience du membre inférieur résultant d'autres troubles du genou

Tableau 42. Barème de taux réduits à la déficience du membre inférieur résultant d'autres troubles du genou

La CAT, les travailleurs et les employeurs ont 45 jours à compter de la date de la lésion pour déposer une demande de la CAT afin qu'elle détermine à nouveau son degré de déficience permanente. La CAT a le droit de demander à la CAT de fournir des données supplémentaires pour évaluer la déficience permanente. La CAT a le droit de demander à la CAT de fournir des données supplémentaires pour évaluer la déficience permanente.

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La CAT, les travailleurs et les employeurs ont 45 jours à compter de la date de la lésion pour déposer une demande de la CAT afin qu'elle détermine à nouveau son degré de déficience permanente. La CAT a le droit de demander à la CAT de fournir des données supplémentaires pour évaluer la déficience permanente. La CAT a le droit de demander à la CAT de fournir des données supplémentaires pour évaluer la déficience permanente.

Amputation	% de déficience du membre inférieur
Au niveau de l'articulation	90
Mobilité anormale*	
L'ampleur moyenne des mouvements de flexion et d'extension est de 150°	
Flexion active réduite :	% de déficience du membre inférieur
0°	53
10°	42
20°	42
30°	42
40°	39
50°	32
60°	28
70°	25
80°	21
90°	18
100°	14
110°	11
120°	7
130°	4
140°	0
150°	0
Extension (jusqu'à retard d'extension)	% de déficience du membre inférieur
0° (position neutre)	0
10°	17
20°	17
30°	27
40°	27
50° à 150° (flexion complète)	90

Troubles	Déficience du membre inférieur*
1. Plectectomie (avec tabess musculeuse)	5-15 %, combiné à une déficience relative à la perte de mobilité*
2. Déchirure méniscale, méniscomiome ou méniscomiome partielle	0-10 %, pour un ménisque; 0-25 %, pour des deux ménisques; combiné à une déficience relative à la perte de mobilité*
3. Arthralgie avec remplacement du ligament du genou	0-15 %, combiné à une déficience relative à la perte de mobilité*
4. Remplacement de la rotule seulement	0-15 %, combiné à une déficience relative à la perte de mobilité*
5. Arthrose attribuable à une arthrose, y compris un traumatisme, une chondromalacie	0-15 %, combiné à une déficience relative à la perte de mobilité*
6. Rupture du ligament croisé antérieur	0-15 %, combiné à une déficience relative à la perte de mobilité*
7. Rupture du ligament croisé postérieur	0-15 %, combiné à une déficience relative à la perte de mobilité*
8. Rupture du ligament latéral	0-15 %, combiné à une déficience relative à la perte de mobilité*
9. Déformation post-traumatique en varus (au-dessus de 15°)	0-15 %, combiné à une déficience relative à la perte de mobilité*
10. Déformation post-traumatique en valgus (au-dessus de 20°)	0-15 %, combiné à une déficience relative à la perte de mobilité*

Tableau des valeurs combinées
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

Tableau 46. Effet de la déficience du membre inférieur sur la personne globale
Indemnité pour PNE = (Montant de base + total - Facteur de rajustement selon l'âge) X % de déficience permanente
Indemnité pour PNE = 150 973,19 \$ + (18 X 1 332,63 \$) X 7 %
Indemnité pour PNE = 4 99



Bracketed numbers, e.g., (01-02-03), are Operational Policy manual document numbers.

Section numbers, e.g., s 5(4), are sections under the Workers' Compensation Act (the Act).

# Worker's Report of Injury/Disease - Form 6

If a claim file already been set up by you, the WCB has filed in these sections for you and (please indicate) claim number.

Complete the information when your name and address are not listed or your name and/or address are different from above.

The physician/physician assistant/physiotherapist/health care provider is responsible for completing the following information to provide a statement on your claim.

If your employer does not provide you with a copy of Form 6, you may want to send you a copy upon receipt.

If your rate of pay reported on this Form 6 is not what you usually earned, you can ask the WCB to recalculate your earnings. It does so using the amount you earned with the accident employer during the 12 months, or lesser period, before your injury/disease s 4(1)(b), (05-02-02).

Workers' Compensation Board  
Commission des accidents du travail  
2 Bloor Street East  
Toronto, Ontario  
M4W 3L2

Worker's Report of Injury/Disease Form 6

Claim No. 76543217-B  
Last No. 111  
Locker Box 154494  
Issue Date 15/JAN/94  
City: TORONTO, ONTARIO  
Prov: ONT  
Municipality: TORONTO

DAVID CHAN  
1642 MAIN STREET  
TORONTO, ONTARIO M4E 1Z4

MESSAGE TO WORKER  
Please read this message. When you have filled out this report, attach it to the WCB Form 7, and return this report to the WCB. Safety compensation covers your right to rehabilitation services and other benefits.

Personal information relating to you will be collected through computerized databases. The purpose of this workers' compensation data is to be used to administer your claim and programs of the Board. Medical and non-medical information is collected from health care providers, social and agencies, employers and witnesses. Information may be disclosed to the accident employer, external parties, rehabilitation, safety agencies and others as authorized by the Workers' Compensation Act and the Freedom of Information and Protection of Privacy Act. For information about the collection and availability of this form to your employer, contact the distributor responsible for your file.

Worker Information  
Last Name: CHAN, First Name: DAVID, Middle Initial: M, Suffix: E, Title: Carpet cleaner  
Date of Birth: 01/12/63, Social Insurance Number: 999 999 999  
Sex: Male, Language: English, Other language if you speak more than one: French  
Phone: (416) 226-1266, Other phone: (416) 226-1266

Employment Information  
Employer Name: Carpet cleaner, Address: 181 01 194  
Job Title: Carpet cleaner, Date of Injury: 01/12/92, Date of Onset: 01/12/92  
Hours of Work: Full time, Part time, Casual, Seasonal, Night work, Student, Volunteer, Other  
Health Care: Doctor, Physiotherapist, Nurse, Other health care provider

Health Care  
Name of Health Care Provider: Dr. Barkley, 4444 W. 3rd St., Toronto, Ont. M6M 2X1  
Date of Report: 01/12/94, Date of Injury: 01/12/92  
Signature: Dr. Barkley, same as above

Earnings Information  
Your employer reported your earnings to the WCB on the Form 7. Please review the information in section 7 of your copy of the WCB Form 7. If you disagree with the earnings information, you may want to attach a letter of explanation and a pay stub to this form. If applicable, attach a letter of explanation and a pay stub to this form. If applicable, attach a letter of explanation and a pay stub to this form.

Employment Benefits  
Check all that apply: Short-term disability, Long-term disability, Workers' compensation benefits, Other benefits  
Signature: David Chan, Date: 01/12/94

Please read and complete the back of this form

Important Information  
If you are an employer, you must provide a copy of this form to your employee. If you are an employee, you must provide a copy of this form to your employer. If you are a self-employed person, you must provide a copy of this form to the WCB. If you are a self-employed person, you must provide a copy of this form to the WCB.

This is the name of your claims adjudicator, the person who makes the decision to allow or deny your claim for benefits and services under the Act.

The WCB offers all services in English and French. If you speak another language, you will receive services through an interpreter.

A witness is a person who is present, by a hearing agency, to work as an employee, witness, or claimant, work, and experience.

Your earnings may include wages, salaries, overtime, vacation pay, room & board, bonuses, payments for time lost, etc. (05-02-03).

Your claims adjudicator needs as much information as possible about your injury/disease to decide what and how you may receive benefits under the Act.

List any similar work-related and non-work-related injury/disease you have had. Your employer may ask the WCB for a copy of this form to protect you. Please print your name and address on the copy sent to your employer.

Worker's Name: David Chan, Social Insurance Number: 999 999 999, Date of Injury: 01/12/92, Date of Onset: 01/12/92

DAVID CHAN  
1642 MAIN STREET  
TORONTO, ONTARIO M4E 1Z4

Details of Injury/Disease  
Date of Injury: 01/12/92, Time of Injury: 11:00 AM  
Date of Onset: 01/12/92, Time of Onset: 11:15 AM  
My supervisor: Hal Jones

What happened to cause your injury/disease? If known, describe injury, part of body involved and location, left or right side.  
I lifted a cleaning machine out of the company van and as I turned to put it down, I felt a sharp pain in my lower back.

Describe your activities at the time of the injury/disease. Include details of equipment or materials you used and the size and weight of objects you handled.  
I was unloading a steam cleaner from the van. It weighs about 30 pounds.  
Where were you when the injury/disease occurred? If your injury/disease occurred outside Canada, specify province, state or country.  
In the parking lot at a customers place - XYZ Enterprises  
Did anyone else witness or know about your injury/disease? If so, provide details below.  
Name: No

Date of injury: April 16, 1992, Type of injury: lower back, Name & address of your employer at the time of previous injury, if applicable: Chameleon Carpet Cleaning (current employer), Claim Number: 3042 3042-8

Have you returned to any work, with or without pay, since your injury/disease? No, Yes. If yes, give name of employer and dates worked.

Are you a member of a trade union? No, Yes. If yes, give name of trade union.

If yes, do you authorize the trade union to represent you in matters before the Workers' Compensation Board? No, Yes. If yes, give the name and telephone number of union.  
It is an offence to deliberately make false statements to the WCB. I consent to the collection of all information relating to this claim by the WCB. I declare all of the information in this report is true and I claim benefits under the Workers' Compensation Act.  
Signature: David Chan, Date: Jan. 31/94, File Code: (416) 123-6047

In accordance with the Freedom of Information and Protection of Privacy Act, your employer can obtain a copy of this form from the WCB.

Your claims adjudicator needs to know if you returned to work with your accident employer within the class of injury/disease of disease.

If you have an accident while on the job, you must report it to your employer. If you have a work-related injury, you must report it to your employer. If you have a work-related injury, you must report it to your employer.





Bracketed numbers, e.g., (01-02-03), are Operational Policy manual document numbers.

Section numbers, e.g., s. 54(6), are sections under the Workers' Compensation Act (the Act).

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P56

**Workers' Compensation Board** Commission des accidents du travail  
Box 580 Postal Centre 7 Toronto, Ontario M4Y 2S1 FAX: (416) 927-5141

**Employer's Report of Injury/Disease Form 7 (Page 1)**

WCB Use only  
Claim Number: \_\_\_\_\_

**A. Worker Identification**

Last Name: Chan First Name: David  
Address: 1642 Main Street  
City/Town: Toronto Province: Ontario Postal Code: M4E 1Z6

Work Reference Number: 178 Social Insurance Number: 999 999 999  
Occupation at Time of Injury/Disease: carpet cleaner Years Experience in Occupation: 5  
Date of Birth: 01/12/63 Sex: M Date of Injury/Disease: 06/30/94  
Worker's Preferred Language of Service: ☒ English ☐ French  
Other language if worker speaks neither English/French: \_\_\_\_\_

Is the injured person a (self) contractor, independent operator, owner, executive of the business or spouse or relative of the employer? ☐ yes ☒ no  
Area Code: 416 Telephone Number: 123-6047

**B. Employer Identification**

Employer Name: Champion Carpet Cleaning City/Town: Scarborough Province: Ont Rate Number: 010101 923  
Address: 11 Stanley St. Postal Code: M1L 5E2  
Area Code: 416 Telephone Number: 900-2114 Fax Number: 900-2562 Description of Business Activity: carpet cleaners  
Workers' Location, Branch, Plant, Department Where Worker Employed: same as above

Do you have an early return to work, compensation return, or a return to work program in place? ☒ yes ☐ no  
Is the injured worker represented by a union? ☒ yes ☐ no

**C. Temporary Disability**

Following the day that the injury/awareness of disease occurred, will the injured worker be absent from work because of the injury/disease? ☐ unknown ☒ yes ☐ no  
If you answered "no" to the above, will the injured worker as a result of the injury/disease:  
• assume other work duties because the injury/disease prevents them from performing their regular duties? ☐ yes ☒ no  
• earn less than their regular wages because of the injury/disease? ☐ yes ☒ no

**D. Details of Injury/Disease**

Date and hour of injury/awareness of disease: 06/30/94 11:00 a.m. Date and hour Reported to Employer: 07/01/94 11:00 a.m. Date and hour Last Worked: 06/30/94 11:00 a.m. Normal Working Hours on Last Day: 9am to 4pm  
Date and hour Reported to Work: 07/01/94 11:00 a.m. Normal Earnings for Last Day Worked: \$105.00 Do you have any information that the worker could have incurred "to work earlier"? If so, provide details: no

1. What happened to cause the injury/disease? (If further, describe injury, pain if body involved and severity left or right side)  
Worker was lifting cleaning machine out of van and put his back out.

2. Who was the injury/disease reported to? If injury/disease was not reported immediately, provide reason for delay:  
Supervisor - Hal Jones

3. Describe the worker's activities at the time of the injury/disease. Include details of equipment or materials used and the size and weight of objects being moved  
Worker was unloading 30 lb machine from company vehicle

4. Where was the worker when the injury/awareness of disease occurred? If the injury/disease occurred outside of Ontario, specify province, town or county  
at job site - XYZ Enterprises

5. Is there anyone else who may have witnessed or who may know about the injury/disease? If so, provide details below.  
(Name(s) and phone number(s) if available)  
no

Contractors and sub-contractors, independent operators, owners, partners, executive officers, and spouses who work in the business without a wage, must have personal coverage to be considered workers for purposes of the Act (08-02-03).

Workers who employ continuously for one year are entitled to re-employment s. 54(1) (07-05-03). A union worker's return to work is subject to the collective agreement's terms regarding seniority s. 54(15) (07-05-04).

You must accommodate the work on the workplace to the needs of an injured worker s. 54(6) (07-05-07).

Decision-makers use this information to decide if an injured worker will return to regular work duties with full wages the day immediately following the injury/onset of disease.

The WCB may contact witnesses to help determine a worker's entitlement under the Act.

## Employer's Report of Injury/Disease-Form 7

If you wish to use your own identification number (such as a payroll number) for your employee, record it here.

The WCB needs the worker's Social Insurance Number for identification and reporting purposes under the Income Tax Act.

The WCB offers all services in English and French. If you or the worker speak another language, tell the WCB and they will offer service through an interpreter.

Report injuries/diseases that occur in your workplace by your rate group number and firm number only.

Provide as much detail as possible. This helps decision-makers determine entitlement as quickly as possible.

You must continue to contribute to employment benefits (including health care, life insurance, and pension benefits) for one year following the injury if:

- you were contributing to the worker's employment benefits when the injury/disease occurred, and
- the worker was required to contribute to employment benefits before the injury/disease and continues to do so while absent from work s. 7 (05-01-11).

Report earnings information for an injury/disease if the worker:

- is absent from work following the day that the injury/awareness of the disease occurred;
- earns less than regular wages;
- performs other work duties.

Earnings include any remuneration capable of being estimated in terms of money (s. 1(1)), including pay by hourly rate, piece work, salary, commission, vacation pay, room and board, bonus and other taxable benefits (08-04-03).

If a worker's rate of pay at the time of the injury/disease does not represent the usual earnings, you or the worker may request a recalculation using the earnings of the 12 months, or lesser period, immediately before the date of the injury/disease s. 40(1)(b) (05-02-02).

You must complete this field if you are paying the worker full or partial wages while the worker is:

- absent from work, or
- at work but performing another job that pays less than the usual job duties.

If you are a Schedule 1 employer paying advances to a worker for a period during which the worker is eligible for wage loss benefits, the WCB keeps a record of all advances paid. The WCB then sends you and the worker a notice listing the amount of compensation covered by advances (05-01-04).

**Workers' Compensation Board** Commission des accidents du travail  
Box 580 Postal Centre 7 Toronto, Ontario M4Y 2S1 FAX: (416) 927-5141

**Employer's Report of Injury/Disease Form 7 (Page 2)**

Worker's name: Chan, David Social Insurance Number: 999 999 999 Claim Number: \_\_\_\_\_

**E. Health Care**

Did the worker receive health care?  
☒ yes ☐ no ☐ don't know  
If yes, provide the name, address and telephone number of practitioner(s). If different than above:  
Dr. Barkley, Chiropractor

**F. Earnings Information - Do not complete this section if you answered "No" to all questions in Section C on page 1**

Rate of Pay Before Last Injury: \$15.00 Total Weekly Pay Before Injury: 35 Weekly pay hours are regular; please state average weekly hours: 35 ☐ yes ☒ no  
Current or continuing health care: If known, provide the name, address and telephone number of practitioner(s). If different than above:  
not known

Net Claim: 645.6 Net Claim Code: 011 Enter Worker's Usual Work Days: S M T W T F S  
Are Benefit Plan (Health Care, Life Insurance, etc.) contributions continuing? ☒ yes ☐ no ☐ not applicable  
If "no", is the benefit plan a multi-employer benefit plan? ☐ yes ☒ no

The worker also receives the following earnings in addition to the Rate of Pay as reported above. (Check all that apply.)

Benefit	Is this benefit continuous with the worker's usual work days?	If "no", please state value	Frequency
Selection Pay	<input checked="" type="checkbox"/> yes <input type="checkbox"/> no	<u>\$24.00</u>	<input type="checkbox"/> daily <input checked="" type="checkbox"/> weekly
Production Bonus	<input type="checkbox"/> yes <input type="checkbox"/> no	\$	<input type="checkbox"/> daily <input type="checkbox"/> weekly
Profit Sharing	<input type="checkbox"/> yes <input type="checkbox"/> no	\$	<input type="checkbox"/> daily <input type="checkbox"/> weekly
Room and board (and/or benefit) from the worker's personal use of an employer's vehicle	<input type="checkbox"/> yes <input type="checkbox"/> no	\$	<input type="checkbox"/> daily <input type="checkbox"/> weekly
Cost of living allowance, shift differential, food hand premium	<input type="checkbox"/> yes <input type="checkbox"/> no	\$	<input type="checkbox"/> daily <input type="checkbox"/> weekly
Tips and Gratuities	<input type="checkbox"/> yes <input type="checkbox"/> no	\$	<input type="checkbox"/> daily <input type="checkbox"/> weekly
Unemployment insurance benefits paid in a job creation or work-sharing program	<input type="checkbox"/> yes <input type="checkbox"/> no	\$	<input type="checkbox"/> daily <input type="checkbox"/> weekly

Identify type of Employment (check all that apply):  
☒ Full Time ☐ Part Time ☐ Casual ☐ Seasonal ☐ Apprentice ☐ Student ☐ Learner ☐ Other

If the worker worked prior to the last absence, please enter dates:  
From: \_\_\_\_\_ month \_\_\_\_\_ year To: \_\_\_\_\_ month \_\_\_\_\_ year

**G. Advances** If you have advanced or will be advancing anything to cover period of disability, give particulars including date covered:  
If advances are to be made to another address, please provide:  
\_\_\_\_\_

**H. Claim Information**

To your knowledge has the worker had a previous similar injury/disease? ☐ no ☒ yes  
If yes, provide details: \_\_\_\_\_  
Worker hurt his back before (April 16, 1992). WCB claim # 30423024-8  
Was this previous injury/disease work-related? ☒ yes ☐ no ☐ yes, please explain: \_\_\_\_\_

Is machinery, equipment or a major vehicle was totally or partially responsible for the injury/disease, refer to the exposures on the reverse of the Employer's Copy and provide particulars:  
\_\_\_\_\_

Do you have any reason to doubt that the injury/disease is work-related? ☒ no ☐ yes ☐ yes, please explain: \_\_\_\_\_

Letter of explanation attached? ☒ yes ☐ no  
Who is responsible for arranging the return to work? (Name and telephone number):  
Hal Jones 900-2114

It is an offence to deliberately make false statements to the WCB. I declare that all of the information provided on pages 1 and 2 of this report is true.

Name of Person Completing this Report: Juanita Guzman Title: Health and safety officer  
Signature: J. Guzman Area Code: 416 Telephone Number: 900-2114 Date: Jan 19/94

WCB Use Only  
Acknowledged: \_\_\_\_\_ Date: \_\_\_\_\_ Final: \_\_\_\_\_ Pending: \_\_\_\_\_ Last Time: \_\_\_\_\_ No Last Time: \_\_\_\_\_ Third Party: \_\_\_\_\_ Out of Province: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Paid from: \_\_\_\_\_ Paid to: \_\_\_\_\_

List treatment by medical doctors, surgeons, osteopaths, chiropractors, dentists, druggists, practitioners, chiropractors, hospital emergency departments, walk-in clinics, and nursing care.

Multi-employer benefit plans cover workers of more than one employer, usually by agreement with a union or group of unions. Under the plan, the workers' employment benefits continue to be paid for one year following the injury or onset of disease. Neither the employer nor the worker is required to continue contributions during this year (05-01-11).

List a worker's previous work-related and non-work-related injuries/diseases if you have that information.

The WCB may use this information to transfer claims costs or to pursue court action to recover damages when other individuals, businesses, equipment, or motor vehicles cause or contribute to the work-related injury/disease (01-01-04).

If you doubt an injury/disease is work-related, you must explain what you think the worker was doing when the injury/disease occurred.

The WCB does not generally pay compensation benefits when workers have an injury or disease resulting from:

- doing something other than their workplace duties, such as personal business
- going somewhere which has nothing to do with their employment
- caused solely by serious and wilful misconduct (unless the injury results in death or serious impairment s. 47(1)).

Serious and wilful misconduct is the deliberate disobedience of an order or rule which is enforced, is well known to workers, and designed for their safety. A careless act does not constitute serious and wilful misconduct. If serious and wilful misconduct is involved in the injury/disease, detailed information must be provided.

An authorized representative of your firm must sign the Form 7. If a partner or an executive officer of the company is the injured worker, another authorized officer of the firm must sign the report. Sole owners or independent operators who are injured may sign their own Form 7.

Les références [p. ex., par. 54 (6)] se rapportent à la Loi sur les accidents du travail (la Loi).

Si vous désirez  
propre numéro  
du travailleur (g)  
figurant sur la l  
inscrivez-le ici

La CAT doit connaître le numéro d'assurance sociale du travailleur, conformément aux exigences d'identification et de déclaration de la Loi de l'impôt sur le revenu.

La CAT offre tous ses services en français et en anglais. Si vous ou le travailleur parlez une autre langue, veuillez l'indiquer à la CAT et des services d'interprétation vous seront offerts.

Déclarez les lésions ou les maladies survenant dans votre lieu de travail selon le numéro de taux et le numéro d'entreprise.

Fournissez le plus de détails possible. Ces détails aident les décideurs à déterminer l'admissibilité du travailleur le plus rapidement possible.

- vous devez continuer à verser des cotisations pour les avantages rattachés à l'emploi (soins médicaux, assurance-vie et régime de retraite) à l'égard du travailleur pendant un an après la lésion et si
- vous versiez les cotisations pour les avantages rattachés à l'emploi au moment de la lésion ou de la maladie et si
- le travailleur versait des cotisations pour les avantages rattachés à l'emploi avant la lésion, et continuera de le faire pendant qu'il sera absent du travail (art. 7, 05-01-19).

- s'absenter de son travail le jour suivant la survenue de la lésion ou de la maladie,
- gagner un salaire moins élevé que son salaire normal,
- accomplir d'autres tâches.

Les gains comprennent toute rémunération pouvant être évaluée en argent [paragraphe (1)], y compris la rémunération au taux horaire, la rémunération à la pièce, le salaire, la commission, l'indemnité de vacances, la chambre et les repas, les bonis et la plupart des autres avantages imposables (08-04-03).

Si le taux de salaire du travailleur au moment de la lésion ou de la maladie ne représente pas les gains habituels, vous ou le travailleur pouvez demander un nouveau calcul basé sur les gains des douze mois, ou d'une période plus courte, qui ont précédé immédiatement l'accident ou la maladie [al. 40 (1) b), 05-02-02].

Vous devez remplir cette case si vous versez un salaire complet ou partiel au travailleur pendant qu'il

- est absent de son travail, ou
- est au travail mais accomplit des tâches qui comportent un salaire moins élevé que les tâches habituelles.

Si vous êtes employeur de l'annexe 1 et que vous versez des avances au travailleur pendant la période où le travailleur est admissible à des indemnités pour perte de salaire, la CAT vous rembourse du montant versé.

Si vous êtes employeur de l'annexe 2 et que vous versez des avances au travailleur pendant la période où le travailleur est admissible à des indemnités pour perte de salaire, la CAT inscrit dans un registre le montant de toutes les avances payées. Par la suite, elle vous envoie, ainsi qu'au travailleur, un relevé indiquant le montant des indemnités versées (05-01-04).

[illegible]

Énumérez les soins donnés par les médecins, les chirurgiens, les optométristes, les chiropraticiens, les dentistes, les praticiens ne prescrivant pas de médicaments, les podologues; ainsi que les soins infirmiers et les soins donnés en service des urgences d'un hôpital ou dans une clinique sans rendez-vous.

Les régimes d'avantages sociaux interentreprises couvrent les travailleurs de plusieurs employeurs, habituellement au moyen d'une entente conclue avec le syndicat ou un groupe de syndicats. Dans le cadre du régime, le travailleur continue d'avoir droit à de tels avantages pendant un an. Ni l'employeur ni le travailleur ne sont tenus de continuer à verser de cotisations pendant cette année-là (05-01-11).

Si connues, énumérez les lésions ou les maladies antérieures du travailleur, qu'elles-ci soient reliées au travail ou non.

La CAT peut utiliser ces renseignements pour verser le coût d'indemnisation ou l'intenter des poursuites en dommages et intérêts lorsqu'une personne, une machine, un équipement ou un véhicule a causé la lésion ou la maladie reliée au travail ou y a contribué (01-01-04).

Lorsque vous doutez qu'une lésion ou une maladie est reliée au travail, vous devez expliquer ce que vous croyez que le travailleur faisait.

En règle générale, la CAT ne verse pas d'indemnités lorsque le travailleur :

- accomplit autre chose que les tâches du lieu de travail, par exemple en vaquant à ses affaires personnelles;
- se rend en un lieu qui n'a rien à voir avec son travail;
- subit une lésion qui est due seulement à une **inconduite grave et volontaire**, à moins que la lésion n'inflige la mort ou une déficience grave [par. 4 (7)].

Par «inconduite grave et volontaire», on entend la désobéissance délibérée à un ordre ou à un règlement en vigueur, connu des travailleurs, et visant à assurer leur sécurité. Une simple négligence ne constitue pas une inconduite grave et volontaire.

Si vous pensez qu'un lésion ou une maladie est reliée au travail, mais qu'il s'agit d'une lésion ou d'une maladie causée par une **inconduite grave et volontaire**, il faut expliquer :

Les entrepreneurs et les sous-traitants, les exploitants indépendants, les propriétaires, les associés et les agents administratifs d'une entreprise, ainsi que les conjoints qui travaillent dans l'entreprise sans salaire, doivent souscrire une protection individuelle pour être considérés comme travailleurs au sens de la Loi (08-02-03).

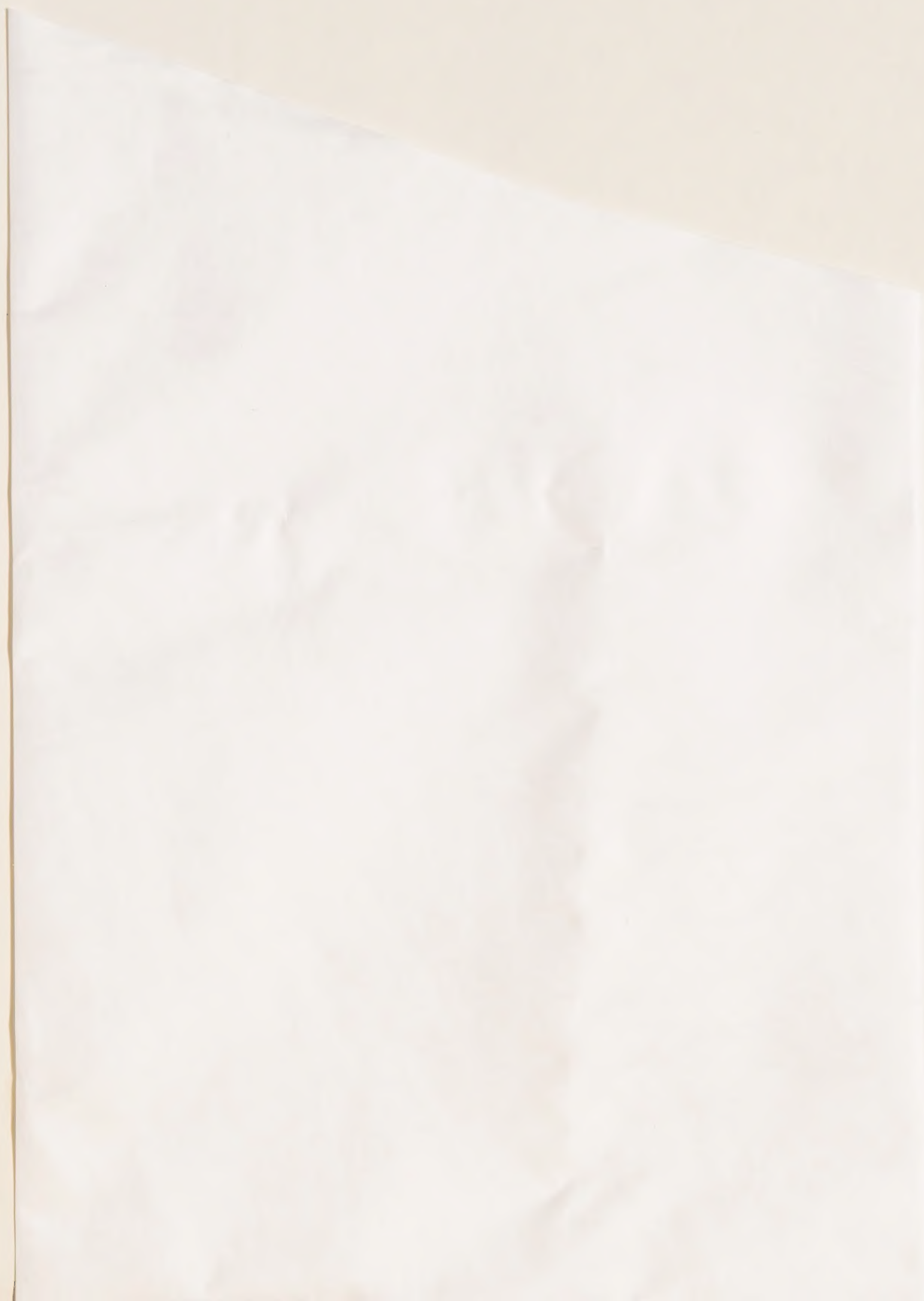
Les travailleurs engagés de façon ininterrompue depuis au moins un an ont droit au engagement (par. 54 (1), 07-05-03). Le retour au travail d'un travailleur syndiqué est assujéti aux dispositions de la convention collective qui se rapportent à l'ancienneté (par. 54 (15), 07-05-04).

**Vous devez adapter le travail ou le lieu de travail aux besoins du travailleur blessé [par. 54 (6), 07-05-07].**

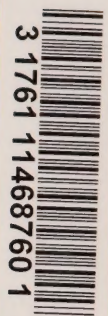
Les décideurs utilisent ces renseignements pour déterminer si un travailleur blessé reprendra son travail régulier, sans perte de salaire, le jour suivant la survenue de la lésion ou de la maladie.

La CAT peut communiquer avec des témoins pour aider à déterminer l'admissibilité du travailleur en vertu de la Loi.









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